# *EDI Billing*
# User Guide
## October 2004


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**Department of Veterans Affairs**
**Veterans Health Administration**

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# 1. INTRODUCTION

In 1996, Congress passed into law the Health Insurance Portability and Accountability Act (HIPAA). This Act directs the federal government to adopt national electronic standards for automated transfer of certain health care data between health care payers, plans, and providers. Now that these standards are in place, the Veterans Health Administration (VHA) will submit claims containing the required standard data content to all payers accepting electronic data interchange (EDI).

## 1.1. Revenue Process

The overall patient billing revenue process for the VHA is summarized in the table below:

**Revenue Cycle**

| Intake | UR | Billing | Collection | UR |
|---|---|---|---|---|
| ➢ Patient Registration<br>➢ Insurance Identification<br>➢ Insurance Verification | ➢ Pre-certification & Certification<br>➢ Continued Stay | ➢ Documentation<br>➢ EDI Bill Generation<br>➢ MRA<br>➢ Claim status messages | ➢ Establish Receivables<br>➢ A/R Follow-up<br>➢ Lockbox<br>➢ Collection Correspondence | ➢ Appeals |

During the Intake phase, the patient is registered. Insurance information is identified and/or verified.

In the Utilization Review phase, the patient is pre-certified and certified, and continued stay reviews are performed.

In the Billing phase, the patient encounter is documented and coded. An electronic data interchange (EDI) bill and/or Medicare Remittance Advice (MRA) request is generated and sent to the payer. Claim status messages include information that appears on the Claims Status Awaiting Resolution (CSA) report.

During the Collections phase, establishment of receivables, accounts receivables follow-up, lockbox, and any collection correspondence take place.

Another Utilization Review can take place if there are any appeals.

EDI Billing provides the VHA with the capability to submit electronic Institutional & Professional claims, rather than printing and mailing claims from each facility.

## 1.2. Critical EDI Process Terms

- **835** - The HIPAA adopted standard for electronic remittance advice to report the processing of all claim types (including retail pharmacy). The term "835" represents the data set that is sent from health plans to health care providers and contains detailed information about the processing of the claim. This includes payment information and reduction or rejection reasons. All health plans are required to use the same explanation of benefit codes (adjustment reason codes) and adhere to very specific reporting requirements. The term "835" is used interchangeably with electronic remittance advice (ERA) and Medicare remittance advice (MRA).

- **837** - The HIPAA adopted standard for electronic submission of hospital, outpatient and dental claims. The term "837" represents the data set that is sent from health care providers to insurance companies (payers). The 837 standard includes the data required for coordination of benefits and is used for primary and secondary payer claims submission. The term "837" is used interchangeably with electronic claim.

- **Claim Status Message** – Electronic messages returned to the VAMC providing status information on a claim from the Financial Service Center (FSC) in Austin, Texas. These messages can originate at FSC, at the payer or at Emdeon™.

- **Clearinghouse** - A company that provides batch and real-time transaction processing services and connectivity to a payer or provider. Transactions include insurance eligibility verification, claims submission processing, electronic remittance processing and payment posting for electronic claims.

- **eClaim** - A claim that is transmitted to FSC electronically.

- **EDI** – Electronic Data Interchange (EDI) is the process of transacting business electronically. It includes submitting claims electronically (paperless claims processing), as well as electronic funds transfer and electronic inquiry for claim status and patient eligibility.

- **Emdeon™** – The clearinghouse used by VA.

- **EOB** – An Explanation of Benefits (EOB) reports the disposition of an individual claim. Many EOBs may be contained within a single 835 Electronic Remittance Advice (ERA) file.

- **ePayer** - Payer that accepts electronic claims from the clearinghouse.

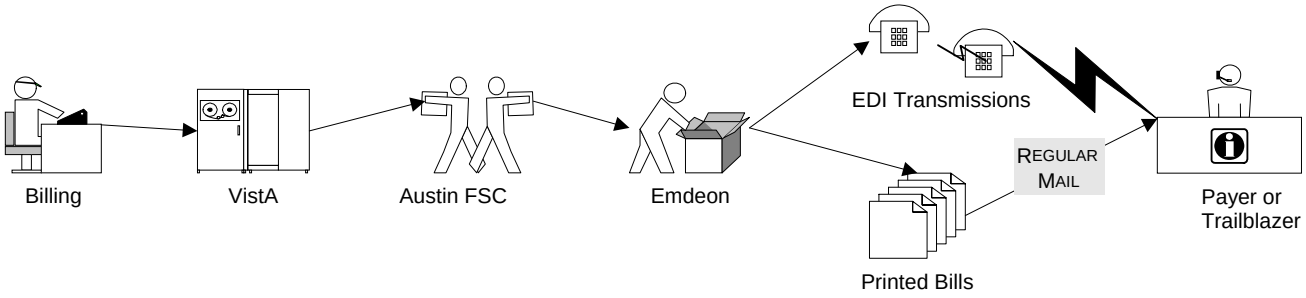
- **Express Bill** – An Emdeon™ printing service that prints and mails claims to payers who do not have the capability to accept electronic claims or in specific circumstances when a paper claim is required.

- **Fiscal Intermediary** – A fiscal intermediary performs services on behalf of health care payers. These services include claim adjudication, reimbursement and collections. Trailblazer Health Enterprises is an example of a fiscal intermediary that acts on behalf of Medicare. Trailblazer receives claims from the VA in the form of an 837 file and then adjudicates the claims to create a MRA 835 file.

- **FSC** – The Financial Service Center (Austin, Texas) receives 837 claims transmissions from VistA and transmits this data to Emdeon™. FSC also receives error/informational messages and 835 data from Emdeon™and transmits this data to VistA.

- **HIPAA** – In 1996 Congress passed into law the Health Insurance Portability and Accountability Act (HIPAA). This Act is comprised of two major legislative actions: Health Insurance Reform and Administrative Simplification. The Administrative Simplification provisions of HIPAA direct the federal government to adopt national electronic standards for automated transfer of certain health care data between health care payers, plans, and providers. This will enable the entire health care industry to communicate electronic data using a single set of standards thus eliminating all non-standard formats currently in use. Once these standards are in place, a health care provider will be able to submit a standard transaction for eligibility, authorization, referrals, claims, or attachments containing the same standard data content to any health plan. This will "simplify" many clinical, billing, and other financial applications and reduce costs.

## 1.3. EDI Process Flow




The above flowchart (EDI Process Flow) represents the path electronic claims follow. The objective of electronic billing is to submit completely correct claims. Claims sent electronically reach the payer faster, are processed faster, and are paid faster than claims submitted on paper via the mail.

From the user's desktop, the claim goes to the FSC in Austin, TX as a VistA Mailman message. The FSC translates the claim into the HIPAA 837 format and forwards it to Emdeon™.

From Emdeon™, the arrow pointing upwards represents the path claims travel if they can be submitted electronically to the payer. If Emdeon™ does not have an electronic connection with a payer or if specific claims must be submitted on paper, the claim is printed at Express Bill and mailed to the payers.

Electronic claims status messages from ePayers return to the VAMCs along the same path. Payers receiving printed claims do not return electronic messages. However, Emdeon™ will return a message indicating that the claim was printed and mailed.

Different electronic edits are in place at each transmission point that may initiate the sending of a claims status message. Claim status messages returned by the clearinghouse and/or payer will provide information on a specific claim. There is no standard content for messages. The information contained within a claim status message varies from payer to payer.

# 2. INSURANCE COMPANY SET-UP

The most common cause of claims rejection is the improper setup of the insurance company and/or provider IDs within VistA. With EDI Billing, there are fields in an 837 claim transmission that are auto-populated with the data defined in VistA. This information must be accurate to generate a clean electronic claim.

## 2.1. Insurance Company Setup

### 2.1.1 Activate New Payer To Transmit eClaims

The typical business process for setting up new payers is:

1. The Insurance Verification Office initially enters a new payer into VistA.
2. Lists of new payers are printed and provided to the medical center's billing office on a regular basis (daily/weekly). Some individuals become members of the IB New Insurance mail group so they receive e-mail bulletins whenever a new insurance policy is added to VistA.
3. Billing staff use the Insurance Company Editor to define Provider IDs: Type of Coverage; Electronic Insurance Type and Electronic Transmit? by Insurance Company. The Profession/Institutional Electronic Bill ID is also defined using the Insurance Company Editor.
4. Billing staff use the Insurance Company Editor to specify the correct Electronic Plan Type for each Insurance Plan.

*Selecting the correct electronic plan type is important. This field may determine which provider IDs are transmitted and/or printed by Express Bill. Choosing the wrong electronic plan type for an Insurance Plan could result in claims being rejected by Emdeon™ or by the payer.*

#### 2.1.1.1 Define EDI settings for a Blue Cross/Blue (BC/BS) Shield Insurance Company.

| Step | Procedure |
|---|---|
| 1 | At the Billing Parameters screen in the Insurance Company Editor, enter **BP – Billing Parameters**. |

```
Insurance Company Editor      Nov 29, 2005@13:54:27          Page:    1 of    7
Insurance Company Information for: BLUE CROSS BLUE SHIELD DEMO
Type of Company: BLUE CROSS                    Currently Active

                          Billing Parameters
  Signature Required?: NO                          Billing Phone: 800 677-6669
           Reimburse?: WILL REIMBURSE         Verification Phone: 800 677-6669
    Mult. Bedsections: YES                    Precert Comp. Name:
     Diff. Rev. Codes:                             Precert Phone: 800 274-7767
       One Opt. Visit: NO                            *** EDI Parameters ***
  Amb. Sur. Rev. Code:                              Transmit?: YES-LIVE
  Rx Refill Rev. Code: 253                        Inst Payer ID: 47198
    Filing Time Frame: SIX MONTHS                 Prof Payer ID: 47198
     Type Of Coverage: BLUE CROSS                Insurance Type: HMO
    Primary Form Type:                               Bin Number:

+         Enter ?? for more actions                                        >>>
BP  Billing Parameters    IO  Inquiry Office        EA  Edit All
MM  Main Mailing Address  AC  Associate Companies   AI  (In)Activate Company
IC  Inpt Claims Office    ID  Prov IDs/ID Param     CC  Change Insurance Co.
OC  Opt Claims Office     PA  Payer                 DC  Delete Company
PC  Prescr Claims Of      RE  Remarks               VP  View Plans
AO  Appeals Office        SY  Synonyms              EX  Exit
Select Action: Next Screen//BP Billing Parameters
```

| Step | Procedure |
|---|---|
| | *Patch IB*2.0*320 added a new security key, **IB EDI INSURANCE EDIT**. A user must hold this key to edit the EDI-Transmit, EDI Prof Payer ID; EDI Inst Payer ID and EDI-Insurance Type fields.* |
| 2 | At the **EDI - Transmit?**: prompt, enter **1** to change the field to **YES-LIVE**. |
| 3 | Because this is a Blue Cross/Blue Shield Insurance Company, enter the **EDI – Prof Payer ID:** and **EDI – Inst Payer ID:** numbers provided by the EDI Implementation Manager at Emdeon™. |
| | *When editing these fields for a commercial payer, (not BC/BS) these fields may be left blank. Emdeon™ will try to match the VistA payer name and address to an entry in its Payer Lookup Table and auto-populate these fields. Payer ID numbers are available at* www.envoy.com. |
| 4 | At the **EDI - Insurance Type**: prompt, enter **??** to see the choices available. For this example, select **Group Policy**. This will result in a checkmark in the GROUP insurance box of the HCFA 1500/BOX 1. |
| 5 | Press the **Return** key until the Billing Parameters screen reappears. |

```
Select Action: Next Screen// BP   Billing Parameters

SIGNATURE REQUIRED ON BILL?: NO//
REIMBURSE?: WILL REIMBURSE//
ALLOW MULTIPLE BEDSECTIONS: YES//
DIFFERENT REVENUE CODES TO USE:
ONE OPT. VISIT ON BILL ONLY: NO//
AMBULATORY SURG. REV. CODE: 490//
PRESCRIPTION REFILL REV. CODE: 250//
BIN NUMBER:
FILING TIME FRAME: ONE YR FROM DATE OF SVC//
FORM TYPE: UB-92//
TYPE OF COVERAGE: HEALTH INSURANCE//
BILLING PHONE NUMBER: 800-555-1212//
VERIFICATION PHONE NUMBER: 800-555-1234//
Are Precerts Processed by Another Insurance Co.?: NO
        //
PRECERTIFICATION PHONE NUMBER:
EDI – Transmit?: ?
     Enter 1 to bill electronically; 0 to print bills for this insurance co; 2
     to only transmit for testing
     Choose from:
       0        NO
       1        YES-LIVE
       2        YES-TEST
EDI – Transmit?: YES-LIVE//
EDI - Inst Payer ID: Refer to Step 3
EDI - Prof Payer ID: Refer to Step 3
EDI - Insurance Type: GROUP POLICY
```

### 2.1.1.2 Define EDI settings for a Blue Cross/Blue Shield Group Insurance Plan:

| Step | Procedure |
|---|---|
| 1 | At the Billing Parameters Screen in the Insurance Company Editor, enter **VP** - **View Plans** and press the **Return** key. |

```
Insurance Company Editor      Nov 29, 2005@14:30:50          Page:    1 of    7
Insurance Company Information for: BLUE CROSS OF CALIFORNIA
Type of Company: BLUE CROSS                    Currently Active

                          Billing Parameters
  Signature Required?: NO                          Billing Phone: 800 677-6669
           Reimburse?: WILL REIMBURSE         Verification Phone: 800 677-6669
    Mult. Bedsections: YES                    Precert Comp. Name:
     Diff. Rev. Codes:                             Precert Phone: 800 274-7767
       One Opt. Visit: NO                            *** EDI Parameters ***
  Amb. Sur. Rev. Code:                              Transmit?: YES-LIVE
  Rx Refill Rev. Code: 253                        Inst Payer ID: 47198
    Filing Time Frame: SIX MONTHS                 Prof Payer ID: 47198
     Type Of Coverage: BLUE CROSS                Insurance Type: GROUP
    Primary Form Type:                               Bin Number:

+         Enter ?? for more actions                                        >>>
BP  Billing Parameters    IO  Inquiry Office        EA  Edit All
MM  Main Mailing Address  AC  Associate Companies   AI  (In)Activate Company
IC  Inpt Claims Office    ID  Prov IDs/ID Param     CC  Change Insurance Co.
OC  Opt Claims Office     PA  Payer                 DC  Delete Company
PC  Prescr Claims Of      RE  Remarks               VP  View Plans
AO  Appeals Office        SY  Synonyms              EX  Exit
Select Action: Next Screen//VP View Plans
```

| Step | Procedure |
|---|---|
| 2 | The Insurance Plan List appears. In this example, Plan 1 is selected by typing **VP=1** and pressing the **Return** key. |

```
Insurance Plan List            Mar 31, 2004@16:12:52          Page:    1 of    1
All Plans for: BLUE CROSS BLUE SHIELD DEMO Insurance Company

#  + => Indiv. Plan    * => Inactive Plan                          Pre-  Pre-  Ben
    Group Name          Group Number       Type of Plan    UR?   Ct?   ExC?  As?
1   DEMO FOR TRAINING   87654              COMPREHENSIVE   NO    YES   YES   YES



          Enter ?? for more actions
VP  View/Edit Plan                      IP  (In)Activate Plan
AB  Annual Benefits                     EX  Exit
Select Action: Quit// VP=1
```

| Step | Procedure |
|---|---|
| 3 | The View/Edit Plan screen appears. To edit plan information, type **PI** and press the **Return** key. |

```
View/Edit Plan                Mar 31, 2004@16:19:51          Page:    1 of    3
Plan Information for: BLUE CROSS BLUE SHIE Insurance Company
                                      ** Plan Currently Active **

  Plan Information                              Utilization Review Info
    Is Group Plan: YES                                 Require UR: NO
       Group Name: DEMO FOR TRAINING                Require Amb Cert: YES
     Group Number: 87654                            Require Pre-Cert: YES
     Type of Plan: COMPREHENSIVE MAJOR MED          Exclude Pre-Cond: YES
   Plan Filing TF:                                Benefits Assignable: YES

  Plan Coverage Limitations
   Coverage             Effective Date   Covered?       Limit Comments
   --------             --------------   --------       --------------
   INPATIENT            02/10/04         YES
   OUTPATIENT           02/10/04         YES
   PHARMACY             02/10/04         NO
+         Enter ?? for more actions
PI  Change Plan Info                     IP  (In)Activate Plan
UI  UR Info                              AB  Annual Benefits
CV  Add/Edit Coverage                    CP  Change Plan
PC  Plan Comments                        EX  Exit
Select Action: Next Screen// PI   Change Plan Info
```

| Step | Procedure |
|---|---|
| 4 | For this scenario **NO** is typed in for the **Do you wish to change this plan to an Individual Plan?** field. |
| 5 | Continue to press the **Return** key until **Electronic Plan Type** field is displayed. |
| 6 | Type in the appropriate code and press the **Return** key. The chosen plan will be displayed. In this example **BL** has been selected. |

*Selecting the correct electronic plan type is critical. The electronic plan type for BC/BS payers should usually be set to **BL** - not commercial. Choosing the wrong electronic plan type for a Group Insurance Plan could result in claims being rejected by Emdeon™ or by the payer.*

```
This plan is currently defined as a Group Plan.
Do you wish to change this plan to an Individual Plan? NO
No change was made.

GROUP PLAN NAME: DEMO GROUP//
GROUP PLAN NUMBER: 7878787878//
TYPE OF PLAN: COMPREHENSIVE MAJOR MED
ELECTRONIC PLAN TYPE: ?
Enter the appropriate type of plan to be used for electronic billing.
     Choose from:
       16       HMO MEDICARE
       MX       MEDICARE A or B
       TV       TITLE V
       MC       MEDICAID
       BL       BC/BS
       CH       TRICARE
       15       INDEMNITY
       CI       COMMERCIAL
       HM       HMO
       DS       DISABILITY
       12       PPO
       13       POS
       ZZ       OTHER
ELECTRONIC PLAN TYPE: BL  BCBS
```

The following screen will display.

```
View/Edit Plan                Mar 31, 2004@16:19:51          Page:    1 of    3
Plan Information for: BLUE CROSS BLUE SHIE Insurance Company
                                      ** Plan Currently Active **

  Plan Information                          Utilization Review Info
    Is Group Plan: YES                             Require UR: NO
       Group Name: DEMO FOR TRAINING         Require Amb Cert: YES
     Group Number: 87654                     Require Pre-Cert: YES
     Type of Plan: COMPREHENSIVE MAJOR MED   Exclude Pre-Cond: YES
   Electronic Type: BC/BS                    Benefits Assignable: YES



+         Enter ?? for more actions

Select Action: Next Screen//
```

### 2.1.2 Activate Existing Commercial Payer To Transmit eClaims

To activate a payer to receive electronic claims, use the Billing Parameters screen in the Insurance Company Editor. The **EDI - Transmit?** field on this screen must be set to **YES-LIVE.** In the Live mode, bills are automatically sent electronically and cannot be printed until the confirmation of a receipt message has been received from the FSC.

Follow these steps to change the **EDI - Transmit?** Field:

| Step | Procedure |
|---|---|
| 1 | On the Billing Parameters screen in the Insurance Company Editor, type **BP** and press the **Return** key. |

```
Insurance Company Editor      Nov 29, 2005@14:30:50          Page:    1 of    7
Insurance Company Information for: AETNA DEMO
Type of Company: BLUE CROSS                      Currently Active

                           Billing Parameters
  Signature Required?: NO                          Billing Phone: 800 677-6669
           Reimburse?: WILL REIMBURSE          Verification Phone: 800 677-6669
    Mult. Bedsections: YES                     Precert Comp. Name:
     Diff. Rev. Codes:                              Precert Phone: 800 274-7767
       One Opt. Visit: NO                             *** EDI Parameters ***
  Amb. Sur. Rev. Code:                                   Transmit?: NO
  Rx Refill Rev. Code: 253                             Inst Payer ID:
    Filing Time Frame: SIX MONTHS                      Prof Payer ID:
     Type Of Coverage: BLUE CROSS                    Insurance Type:
    Primary Form Type:                                    Bin Number:

+         Enter ?? for more actions                                          >>>
BP  Billing Parameters    IO  Inquiry Office        EA  Edit All
MM  Main Mailing Address  AC  Associate Companies   AI  (In)Activate Company
IC  Inpt Claims Office    ID  Prov IDs/ID Param     CC  Change Insurance Co.
OC  Opt Claims Office     PA  Payer                 DC  Delete Company
PC  Prescr Claims Of      RE  Remarks               VP  View Plans
AO  Appeals Office        SY  Synonyms              EX  Exit
Select Action: Next Screen// BP Billing Parameters
```

| Step | Procedure |
|---|---|
| | *Patch IB*2.0*320 added a new security key, **IB EDI INSURANCE EDIT**. A user must hold this key to edit the EDI-Transmit, EDI Prof Payer ID; EDI Inst Payer ID and EDI-Insurance Type fields.* |
| 2 | At the **EDI - Transmit?** field, type **1** to change the field to **YES-LIVE**. |
| 3 | At the **EDI - Insurance Type** field, enter the correct response for the Insurance Company being edited. For this example, the correct Electronic Insurance Type is **Group**. |
| | Except for the testing of Primary BC/BS and AARP claims, it is no longer necessary to change the **EDI - Transmit?** field to **YES-TEST**. Instead, use the new option, **RCB – View/Resubmit Claims-Live or Test**. Refer to **Section 4**. |

```
SIGNATURE REQUIRED ON BILL?: NO//
REIMBURSE?: WILL REIMBURSE//
ALLOW MULTIPLE BEDSECTIONS: YES//
DIFFERENT REVENUE CODES TO USE:
ONE OPT. VISIT ON BILL ONLY: NO//
AMBULATORY SURG. REV. CODE:
PRESCRIPTION REFILL REV. CODE: 253//
BIN NUMBER:
FILING TIME FRAME: ONE YEAR//
FORM TYPE:
TYPE OF COVERAGE: HEALTH INSURANCE//
BILLING PHONE NUMBER: 800-555-5298//
VERIFICATION PHONE NUMBER: 800-555-5298//
Are Precerts Processed by Another Insurance Co.?: NO
         //
PRECERTIFICATION PHONE NUMBER: 800-555-7799//
EDI - Transmit?: ??
        This is the flag that says whether or not an insurance company is ready
        to be billed electronically via 837/EDI functions.

     Choose from:
       0        NO
       1        YES-LIVE
       2        YES-TEST
EDI - Transmit?: 1  YES-LIVE
EDI – Prof ID: Number available from Emdeon™
EDI – Inst ID: Number available from Emdeon™
EDI – Insurance Type: ??
     Choose from:
       1        HMO
       2        COMMERCIAL
       3        MEDICARE
       4        MEDICAID
       5        GROUP POLICY
       9        OTHER
EDI – Insurance Type: 5 GROUP POLICY
```

The following steps show you how to enter the Electronic Plan Type for a **Commercial Group Insurance Plan**:

| Step | Procedure |
|---|---|
| 1 | At the Billing Parameters Screen in the Insurance Company Editor type in **VP** (View Plans) and press the **Return** key. |

```
Insurance Company Editor      Nov 29, 2005@14:38:23          Page:    1 of    7
Insurance Company Information for: AETNA DEMO
Type of Company: BLUE CROSS                    Currently Active

                          Billing Parameters
  Signature Required?: NO                          Billing Phone: 800 677-6669
           Reimburse?: WILL REIMBURSE         Verification Phone: 800 677-6669
    Mult. Bedsections: YES                     Precert Comp. Name:
     Diff. Rev. Codes:                              Precert Phone: 800 274-7767
       One Opt. Visit: NO                             *** EDI Parameters ***
  Amb. Sur. Rev. Code:                               Transmit?: YES-LIVE
  Rx Refill Rev. Code: 253                         Inst Payer ID: EMDEON™ #
    Filing Time Frame: SIX MONTHS                  Prof Payer ID: EMDEON™ #
     Type Of Coverage: BLUE CROSS                 Insurance Type: GROUP
    Primary Form Type:                               Bin Number:

+         Enter ?? for more actions                                        >>>
BP  Billing Parameters    IO  Inquiry Office        EA  Edit All
MM  Main Mailing Address  AC  Associate Companies   AI  (In)Activate Company
IC  Inpt Claims Office    ID  Prov IDs/ID Param     CC  Change Insurance Co.
OC  Opt Claims Office     PA  Payer                 DC  Delete Company
PC  Prescr Claims Of      RE  Remarks               VP  View Plans
AO  Appeals Office        SY  Synonyms              EX  Exit
Select Action: Next Screen// VP View Plans
```

| Step | Procedure |
|---|---|
| 2 | The Insurance Plan List appears. In this example, Plan 1 is selected by typing **VP=1** and pressing the **Return** key. |

```
Insurance Plan List            Apr 14, 2004@09:21:12          Page:    1 of    1
All Plans for: AETNA DEMO INSURANCE Insurance Company

#  + => Indiv. Plan    * => Inactive Plan                        Pre-  Pre-  Ben
    Group Name          Group Number       Type of Plan    UR?  Ct?   ExC?  As?
1   MANAGED CHOICE      55555-111-00001    COMPREHENSIVE   YES  YES   UNK   YES




          Enter ?? for more actions
VP  View/Edit Plan                      IP  (In)Activate Plan
AB  Annual Benefits                     EX  Exit
Select Action: Quit// VP=1
```

| Step | Procedure |
|---|---|
| 3 | The View/Edit Plan screen appears. To edit plan information, type **PI** and press the **Return** key. |

```
View/Edit Plan                  Apr 14, 2004@09:22:11          Page:    1 of    3
Plan Information for: AETNA DEMO INSURANCE Insurance Company
                                        ** Plan Currently Active **

  Plan Information                            Utilization Review Info
    Is Group Plan: YES                               Require UR: YES
       Group Name: MANAGED CHOICE                 Require Amb Cert:
     Group Number: 55555-111-00001                Require Pre-Cert: YES
     Type of Plan: COMPREHENSIVE MAJOR MED        Exclude Pre-Cond:
   Plan Filing TF:                             Benefits Assignable: YES

  Plan Coverage Limitations
   Coverage             Effective Date   Covered?       Limit Comments
   --------             --------------   --------       --------------
   INPATIENT            02/01/04         YES
   OUTPATIENT           02/01/04         YES
   PHARMACY             02/01/04         NO
+         Enter ?? for more actions
PI  Change Plan Info                     IP  (In)Activate Plan
UI  UR Info                              AB  Annual Benefits
CV  Add/Edit Coverage                    CP  Change Plan
PC  Plan Comments                        EX  Exit
Select Action: Next Screen// PI   Change Plan Info
```

| Step | Procedure |
|---|---|
| 4 | For this scenario, **NO** is entered for the **Do you wish to change this plan to an Individual Plan?** field. |
| 5 | Continue to press the **Return** key until **Electronic Plan Type** field is activated. |
| 6 | Type in the appropriate code and press the **Return** key. The chosen plan will be displayed. In this example **CI** has been selected. |

*Selecting the correct electronic plan type is important. Choosing the wrong electronic plan type for a Group Insurance Plan could result in claims being rejected by Emdeon™ or by the payer.*

```
This plan is currently defined as a Group Plan.
Do you wish to change this plan to an Individual Plan? NO
No change was made.

GROUP PLAN NAME: MANAGED CHOICE//
GROUP PLAN NUMBER: 55555-111-00001//
TYPE OF PLAN: COMPREHENSIVE MAJOR MEDICAL//
ELECTRONIC PLAN TYPE: ?
Enter the appropriate type of plan to be used for electronic billing.
     Choose from:
       16       HMO MEDICARE
       MX       MEDICARE A or B
       TV       TITLE V
       MC       MEDICAID
       BL       BC/BS
       CH       TRICARE
       15       INDEMNITY
       CI       COMMERCIAL
       HM       HMO
       DS       DISABILITY
       12       PPO
       13       POS
       ZZ       OTHER
ELECTRONIC PLAN TYPE: CI  COMMERCIAL
PLAN FILING TIME FRAME: .....
```

The following screen will display.

```
View/Edit Plan                Apr 14, 2004@09:24:02          Page:    1 of    3
Plan Information for: AETNA DEMO INSURANCE Insurance Company
                                      ** Plan Currently Active **

  Plan Information                          Utilization Review Info
    Is Group Plan: YES                             Require UR: YES
       Group Name: MANAGED CHOICE                Require Amb Cert:
     Group Number: 55555-111-00001               Require Pre-Cert: YES
     Type of Plan: COMPREHENSIVE MAJOR MED       Exclude Pre-Cond:
  Electronic Type: COMMERCIAL                 Benefits Assignable: YES



+         Enter ?? for more actions

Select Action: Next Screen//
```

### 2.1.3 Activate Existing Payer To Test Primary Blue Cross/Blue Shield eClaims

Blue Cross and Blue Shield payers require the submission of test claims before accepting live claims. Contact the EDI Implementation Manager at Emdeon™ to coordinate this testing.

*When testing the electronic submission of secondary claims using the RCB – View/Resubmit Claims-Live or Test, it is not necessary to change Electronic Transmit? to YES-TEST nor is it necessary to print and mail claims sent using RCB.*

To enable a BC/BS payer to receive primary claims electronically but in a testing mode, use the Billing Parameters screen in the Insurance Company Editor. The **EDI - Transmit?** field on this screen must be set to **YES-TEST.** In testing mode, bills are automatically sent electronically and cannot be printed until the confirmation of receipt message has been received from the FSC.

The following steps show you how to change the **Electronic Transmit?** field:

| Step | Procedure |
|---|---|
| 1 | On the Billing Parameters screen in the Insurance Company Editor type **BP** and press the **Return** key. |

```
Insurance Company Editor      Nov 29, 2005@14:59:10          Page:    1 of    7
Insurance Company Information for: BLUE CROSS OF CALIFORNIA
Type of Company: BLUE CROSS                     Currently Active

                           Billing Parameters
  Signature Required?: NO                          Billing Phone: 800 677-6669
           Reimburse?: WILL REIMBURSE          Verification Phone: 800 677-6669
    Mult. Bedsections: YES                     Precert Comp. Name:
     Diff. Rev. Codes:                              Precert Phone: 800 274-7767
       One Opt. Visit: NO                             *** EDI Parameters ***
  Amb. Sur. Rev. Code:                               Transmit?: NO
  Rx Refill Rev. Code: 253                         Inst Payer ID:
    Filing Time Frame: SIX MONTHS                  Prof Payer ID:
     Type Of Coverage: BLUE CROSS                 Insurance Type:
    Primary Form Type:                               Bin Number:

+         Enter ?? for more actions                                          >>>
BP  Billing Parameters    IO  Inquiry Office        EA  Edit All
MM  Main Mailing Address  AC  Associate Companies   AI  (In)Activate Company
IC  Inpt Claims Office    ID  Prov IDs/ID Param     CC  Change Insurance Co.
OC  Opt Claims Office     PA  Payer                 DC  Delete Company
PC  Prescr Claims Of      RE  Remarks               VP  View Plans
AO  Appeals Office        SY  Synonyms              EX  Exit
Select Action: Next Screen// BP  Billing Parameters
```

| Step | Procedure |
|---|---|
| 2 | At the **EDI - Transmit?** field, type **2** to change the field to **YES-TEST**. Continue to press the **Return** key until the Billing Parameters screen reappears. |

*When using the TEST mode setting for BC/BS claims for which payment is expected, it is important to note the carrier will not process bills sent in test mode. These bills **must be printed locally and mailed** in order to receive payment.*

```
SIGNATURE REQUIRED ON BILL?: NO//
REIMBURSE?: WILL REIMBURSE//
ALLOW MULTIPLE BEDSECTIONS: YES//
DIFFERENT REVENUE CODES TO USE:
ONE OPT. VISIT ON BILL ONLY: NO//
AMBULATORY SURG. REV. CODE: 490//
PRESCRIPTION REFILL REV. CODE: 250//
BIN NUMBER:
FILING TIME FRAME: ONE YEAR FROM DATE OF SERVICE  Replace
FORM TYPE: UB-92//
TYPE OF COVERAGE: HEALTH INSURANCE//
ELECTRONIC INSURANCE TYPE: GROUP POLICY//
BILLING PHONE NUMBER: 205-988-2213//
VERIFICATION PHONE NUMBER: ITS:800-253-9307//
Are Precerts Processed by Another Insurance Co.?: NO
         //
PRECERTIFICATION PHONE NUMBER: 800-248-2342//
EDI - Transmit?: NO// ??
        This is the flag that says whether or not an insurance company is
ready to be billed electronically via 837/EDI functions.

     Choose from:
       0        NO
       1        YES-LIVE
       2        YES-TEST
EDI – Transmit?: YES-TEST//
EDI – Prof Payer ID: 00B00//
EDI – Inst Payer ID: SB0000//
```

# 3. PROVIDER ID SET-UP

Payers require the use of a variety of provider identifiers on claims submitted for adjudication. Printed claim forms have boxes where these IDs can be printed.

The general term, Provider ID, can refer to an ID that belongs to human being such as an Attending physician or it can refer to an ID that belongs to an organization that provides healthcare services to a veteran such as a VAMC or outside laboratory. Both VA and non-VA people and organizations have IDs.

IDs have qualifiers that identify what type of ID is being transmitted. An Attending physician's primary ID is his/her Social Security Number. This SSN is transmitted with a qualifier (34) which indicates that this number is an SSN. A Blue Cross ID is transmitted with a qualifier (1A) which indicates that this number is a Blue Cross number. Appendix C has a list of qualifiers and which ones can be transmitted in which 837 records.

The HIPAA 837 transaction set includes a number of segments in which to transmit multiple IDs and qualifiers for a single claim. The list below indicates the VistA record name, the type of information being transmitted, the maximum number of IDs that can go in that record for one claim and if the IDs will print on a paper claim (P), transmit electronically (T), or do both (B).

| Segment | Type of ID | Max # of IDs | (P)rint (T)ransmit (B)oth |
|---|---|---|---|
| PRV:9 | Billing Provider Primary ID (Federal Tax Number) | 1 | B |
| CL1A:2-17 | Billing Provider Secondary IDs | 8 | B |
| OPR1 | Attending, Other or Operating Physician Primary ID | 1/Physician | B |
| OPR1 | Rendering or Referring Provider Primary ID | 1/Provider | B |
| OPR7 | Supervising Provider's Primary ID | 1/Provider | B |
| OPR2 | Attending Physician or Rendering Provider Secondary ID | 5 | B |
| OPR3 | Operating Physician Secondary IDs | 5 | B |
| OPR4 | Other Physician Secondary IDs | 5 | B |
| OPR5 | Referring Provider Secondary IDs | 5 | B |
| OPR8 | Supervising Provider Secondary IDs | 5 | B |
| SUB | Laboratory or Facility Primary ID | 1 | B |
| SUB1 | Purchased Service Secondary IDs | 5 | T |
| SUB2 | Laboratory or Facility Secondary IDs | 5 | T |

## 3.1. Table of IDs

The following table shows where IDs are defined in VistA; where they are stored in VistA; where they appear on billing forms; and where they appear in the VistA option View/Print EDI Bill Extract Data (VPE) and the EDI 837 transaction record location.

| **Billing Provider Primary ID (Federal Tax Number of the VAMC)** | |
|---|---|
| VistA Option | MCCR Site Parameter Display/Edit |
| VistA File | IB SITE PARAMETERS (#350.9) |
| UB-92 | FL 5 |
| HCFA 1500 | Box 25 (Box 32 unless there is an outside facility) |
| VPE (837 Record) | PRV, Piece 9 |

| **Billing Provider Secondary IDs** | |
|---|---|
| Note: If none are defined, the default is the Federal Tax ID. | |
| VistA Option | Insurance Company Entry/Edit→ID Prov IDs/ID Param |
| VistA File | FACILITY BILLING ID (#355.92) |
| UB-92 | FL 51 |
| HCFA 1500 | Box 33 (Grp # Field) |
| VPE (837 Record) | CI1A, Pieces 2-17 |

| **VA - Attending, Other or Operating Physician Primary ID (SSN)** | |
|---|---|
| VistA Option | Add a New User to the System<br>Edit an Existing User |
| VistA Files | NEW PERSON (#200) |
| UB-92 | FL 82, 83 if Insurance Company parameter is set to print SSN |
| HCFA 1500 | N/A |
| VPE (837 Record) | OPR1, Pieces 3, 6, or 9 |

| **VA – Rendering or Referring Provider Primary ID (SSN)** | |
|---|---|
| VistA Option | Add a New User to the System<br>Edit an Existing User |
| VistA Files | NEW PERSON (#200) |
| UB-92 | N/A |
| HCFA 1500 | Box 17a if Insurance Company parameter is set to print SSN |
| VPE (837 Record) | OPR1, Pieces 3 or 12 |

| **VA – Supervising Provider Primary ID (SSN)** | |
|---|---|
| VistA Option | Add a New User to the System<br>Edit an Existing User |
| VistA Files | NEW PERSON (#200) |
| UB-92 | N/A |
| HCFA 1500 | Not Printed |
| VPE (837 Record) | OPR7, Piece 7 |

| **Non-VA – Attending, Other or Operating Physician Primary ID (SSN))** | |
|---|---|
| VistA Option | Provider ID Maintenance→Non/Other VA Provider→Individual |
| VistA Files | IB BILLING PRACTITIONER ID (#355.9) |
| UB-92 | Not Printed |

| | |
|---|---|
| HCFA 1500 | N/A |
| VPE (837 Record) | OPR1, Pieces 3, 6, or 9 |

**Non-VA – Rendering or Referring Provider Primary ID (SSN)**

| | |
|---|---|
| VistA Option | Provider ID Maintenance→Non/Other VA Provider→Individual |
| VistA Files | IB BILLING PRACTITIONER ID (#355.9) |
| UB-92 | N/A |
| HCFA 1500 | Not Printed |
| VPE (837 Record) | OPR1, Pieces 3 or 12 |

**Non-VA – Supervising Provider Primary ID (SSN)**

| | |
|---|---|
| VistA Option | Provider ID Maintenance→Non/Other VA Provider→Individual |
| VistA Files | IB BILLING PRACTITIONER ID (#355.9) |
| UB-92 | N/A |
| HCFA 1500 | Not Printed |
| VPE (837 Record) | OPR7, Piece 7 |

**VA - Attending, Other or Operating Physician Secondary IDs**

| | |
|---|---|
| VistA Option | Provider ID Maintenance→ Provider Specific IDs→<br>Provider's Own IDs<br>Provider IDs Furnished by Insurance Co |
| VistA Files | New Person (#200)<br>IB Billing Practitioner ID (#355.9) |
| UB-92 | FL 82, 83 unless the SSN is forced to print |
| HCFA 1500 | N/A |
| VPE (837 Record) | OPR2, OPR3, OPR4 Pieces 3, 5, 7, 9 or 11 |

**VA – Rendering or Referring Provider Secondary IDs**

| | |
|---|---|
| VistA Option | Provider ID Maintenance→ Provider Specific IDs→<br>Provider's Own IDs<br>Provider IDs Furnished by Insurance Co |
| VistA Files | New Person (#200)<br>IB Billing Practitioner ID (#355.9) |
| UB-92 | N/A |
| HCFA 1500 | 17a (Referring Provider) unless the SSN is forced to print |
| VPE (837 Record) | OPR2, OPR5, Pieces 3, 5, 7, 9 or 11 |

**VA – Supervising Provider Secondary IDs**

| | |
|---|---|
| VistA Option | Provider ID Maintenance→ Provider Specific IDs→<br>Provider's Own IDs<br>Provider IDs Furnished by Insurance Co |
| VistA Files | New Person (#200)<br>IB Billing Practitioner ID (#355.9) |
| UB-92 | N/A |
| HCFA 1500 | Not Printed |
| VPE (837 Record) | OPR 8, Pieces 3, 5, 7, 9 or 11 |

**Non - VA - Attending, Other or Operating Physician Secondary IDs**

| | |
|---|---|
| VistA Option | Provider ID Maintenance→ Non/Other VA Provider ID Information<br>or<br>Provider ID Maintenance→ Provider Specific IDs→ |

| | |
|---|---|
| | Provider's Own IDs<br>Provider IDs Furnished by Insurance Co |
| VistA Files | IB Billing Practitioner ID (#355.9) |
| UB-92 | FL 82, 83 |
| HCFA 1500 | N/A |
| VPE (837 Record) | OPR2, OPR3, OPR4 Pieces 3, 5, 7, 9 or 11 |

**Non - VA – Rendering or Referring Provider Secondary IDs**

| | |
|---|---|
| VistA Option | Provider ID Maintenance→ Non/Other VA Provider ID Information<br>or<br>Provider ID Maintenance→ Provider Specific IDs→<br>Provider's Own IDs<br>Provider IDs Furnished by Insurance Co |
| VistA Files | IB Billing Practitioner ID (#355.9) |
| UB-92 | N/A |
| HCFA 1500 | 17a (Referring Provider) |
| VPE (837 Record) | OPR2, OPR5, Pieces 3, 5, 7, 9 or 11 |

**Non - VA – Supervising Provider Secondary IDs**

| | |
|---|---|
| VistA Option | Provider ID Maintenance→ Non/Other VA Provider ID Information<br>or<br>Provider ID Maintenance→ Provider Specific IDs→<br>Provider's Own IDs<br>Provider IDs Furnished by Insurance Co |
| VistA Files | IB Billing Practitioner ID (#355.9) |
| UB-92 | N/A |
| HCFA 1500 | Not Printed |
| VPE (837 Record) | OPR8, Pieces 3, 5, 7, 9 or 11 |

**VA - Service Facility – Laboratory or Facility Primary ID (Federal Tax ID)**

| | |
|---|---|
| VistA Option | MCCR Site Parameter Display/Edit<br>Insurance Company Entry/Edit – ID Parameter can be set by Insurance Co. to not transmit this for VA main facility |
| VistA File | IB SITE PARAMETERS (#350.9) |
| UB-92 | Not Printed |
| HCFA 1500 | Box 32 |
| VPE (837 Record) | SUB, Piece 9 and SUB2, Piece 6 |

**VA - Service Facility – Laboratory or Facility Secondary IDs**

| | |
|---|---|
| VistA Option | Insurance Company Entry/Edit →ID Prov IDs/ID Param →VA-Lab/Facility IDs |
| VistA File | FACILITY BILLING ID (#355.92) |
| UB-92 | Not Printed |
| HCFA 1500 | Not Printed |
| VPE (837 Record) | SUB1, Pieces 3, 5, 7, 9, and 11 and SUB2, Pieces 8, 10, 12, 14, 16 |

**Non-VA - Service Facility – Laboratory or Facility Primary ID (Federal Tax ID)**

| | |
|---|---|
| VistA Option | Provider ID Maintenance→ Non/Other VA Provider ID Information→Facility→Provider Info |
| VistA File | IB NON/OTHER VA BILLING PROVIDER (#355.93) |
| UB-92 | Not Printed |

| | |
|---|---|
| HCFA 1500 | Box 32 |
| VPE (837 Record) | SUB, Piece 9 and SUB2, Piece 6 |

**Non-VA - Service Facility – Laboratory or Facility Secondary IDs**

| | |
|---|---|
| VistA Option | Provider ID Maintenance→ Non/Other VA Provider ID Information→Facility→Secondary ID Maint |
| VistA File | IB BILLING PRACTITIONER ID (#355.9) |
| UB-92 | Not Printed |
| HCFA 1500 | Not Printed |
| VPE (837 Record) | SUB1, Pieces 3, 5, 7, 9, and 11 and SUB2, Pieces 8, 10, 12, 14, 16 |

## 3.2. Billing Provider IDs

The Billing Provider Primary ID and the Billing Provider Secondary IDs are IDs which identify the entity which is seeking payment for a claim (who will receive the payment). For claims generated by the VA, the Billing Provider is the VA.

### 3.2.1 Define the Billing Provider Primary ID

For all claims generated by the VA, the Billing Provider Primary ID is always the Federal Tax Number of the site. Once defined, the IB software will automatically assign this ID to a claim.

| Step | Procedure |
|---|---|
| 1 | Access the option **SITE→MCCR Site Parameter Display/Edit**. |
| 2 | From the **MCCR Site Parameters** screen, enter the action, **IB Site Parameters**. |
| 3 | From the **IB Site Parameters screen**, enter the action, **EP Edit Set**. |
| 4 | Press **Return** for Next Screen until Page 2 is displayed. |
| 5 | Enter the action **EP Edit Set**. |
| 6 | At the **Federal Tax Number** prompt, enter the site's Federal Tax Number. |

```
IB Site Parameters            Oct 20, 2005@16:23:16          Page:    2 of    6
Only authorized persons may edit this data.
+
[5] Medical Center     : LOMA LINDA VAMC      Default Division   : JERRY L PETTI
    MAS Service        : PATIENT ELIGIBILITY  Billing Supervisor : IB,SUP1

[6] Initiator Authorize: YES                  Xfer Proc to Sched : NO
    Ask HINQ in MCCR   : YES                  Use Non-PTF Codes  : YES
    Multiple Form Types: YES                  Use OP CPT screen  : YES

[7] Default Form Type  : UB-92                UB-92 Address Col  :
    '001' for Total    : YES                  HCFA 1500 Addr Col : 7

[8] Default RX DX Cd   : 780.99               Default ASC Rev Cd : 490
    Default RX CPT Cd  :                      Default RX Rev Cd  : 251

[9] Bill Signer Name   : <No longer used>     Federal Tax #      :
    Bill Signer Title  : <No longer used>
    Remark on Each Bill: BILL # MUST BE ON ALL REMITTANCE

+         Enter ?? for more actions
EP  Edit Set                                        EX  Exit Action
Select Action: Next Screen// ep   Edit Set
Select Parameter Set(s):  (5-9): 9
NAME OF CLAIM FORM SIGNER: BUSINESS OFFICE//
TITLE OF CLAIM FORM SIGNER:
FEDERAL TAX NUMBER: XX123456
```

### 3.2.2 Define the Billing Provider Secondary IDs

The Billing Provider Secondary IDs are IDs and Qualifiers that are provided to a site by the insurance company. There can be a total of eight Billing Provider Secondary IDs

per claim. The first ID is calculated by the system and used by Emdeon™ to sort claims. The remaining seven IDs must be defined by the IB staff if required.

Users may define one Billing Provider Secondary ID for a HCFA 1500 and another for a UB92 for the main division. If no other Billing Provider Secondary IDs are defined, these two IDs will be the default IDs for all claims.

Billing Provider Secondary IDs can be defined by Division, Form Type and Care Unit.

#### 3.2.2.1 Define Default Billing Provider Secondary IDs by Form Type

| Step | Procedure |
|---|---|
| 1 | Access the option **SYST→Insurance Company Entry/Edit**. |
| 2 | At the **Select Insurance Company Name**: prompt, enter **Blue Cross of California** for this example. |
| 3 | From the **Insurance Company Editor** screen, enter the action, **ID Prov IDs/ID Parameters**. |
| 4 | From the **Billing Provider IDs screen**, enter the action **Add an ID**. |
| 5 | At the **Define Billing Provider Secondary IDs by Care Units? No//** prompt, press **Return** to accept the default of **No**. |
| 6 | At the **Division** prompt, accept the default for the main Division. |
| 7 | At the **ID Qualifier: Electronic Plan Type//** prompt, enter **Blue Shield** to override the default value for this example. |
|  | *Note: The default value for the Billing Provider Secondary ID Qualifier is still based upon the Electronic Plan Type of the patient's insurance plan. Users now have the ability to override this default.* |
| 8 | At the **Form Type** prompt, enter **HCFA 1500** for this example. |
| 9 | At the **Billing Provider Secondary ID** prompt, enter the ID **XXXXXXXX1B** for this example. |
| 10 | Repeat these steps for the Form Type = **UB92**, Qualifier = **Blue Cr**oss and ID = **XXXXXX1A**. |
|  | *Note: If no Billing Provider Secondary IDs are defined, the Federal Tax ID is used as a default value.* |

```
Billing Provider IDs (Parent)        May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co: BLUE CROSS OF CALIFORNIA   Billing Provider Secondary IDs
     ID Qualifier                     ID #             Form Type

No Billing Provider IDs found



          Enter ?? for more actions
    Add an ID            Additional IDs        Exit
    Edit an ID           ID Parameters
    Delete an ID         VA-Lab/Facility IDs

Select Action: Quit// a   Add ID
Define Billing Provider Secondary IDs by Care Units? No//??

   Enter No to define a Billing Provider Secondary ID
   for the Division.
   Enter Yes to define a Billing Provider Secondary ID
   for a specific Care Unit.
   If no Care Unit is entered on Billing Screen 3, the
   Billing Provider Secondary ID defined for the Division will
   be transmitted in the claim.

       0   No
       1   Yes

Define Billing Provider Secondary IDs by Care Units? No//No
Division: Main Division// Main Division
ID Qualifier: Electronic Plan Type//Blue Shield
Enter Form Type for ID: HCFA 1500
Billing Provider Secondary ID: XXXXXXXX
```

The following screen will display. These two IDs will be the default IDs for all claims and will appear on Billing Screen 3.

```
Billing Provider IDs (Parent)        May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co: BLUE CROSS OF CALIFORNIA   Billing Provider Secondary IDs
     ID Qualifier                     ID #             Form Type
Division: Name of Main Division/Default for All Divisions
1    Blue Cross                       XXXXXX1A         UB92
2    Blue Shield                      XXXXXX1B         HCFA




          Enter ?? for more actions
    Add an ID            Additional IDs        Exit
    Edit an ID           ID Parameters
    Delete an ID         VA-Lab/Facility IDs

Select Action: Quit//
```

### 3.2.2.2 Define Billing Provider Secondary IDs by Division and Form Type

If an insurance company requires different Billing Provider Secondary IDs for each division, then users must define more than just the default IDs.

| Step | Procedure |
|---|---|
| 1 | Access the option **SYST→Insurance Company Entry/Edit**. |
| 2 | At the **Select Insurance Company Name**: prompt, enter **Blue Cross of California** for this example. |
| 3 | From the **Insurance Company Editor** screen, enter the action, **ID Prov IDs/ID Parameters**. |
| 4 | From the **Billing Provider IDs screen**, enter the action **Add an ID**. |
| 5 | At the **Define Billing Provider Secondary IDs by Care Units? No//** prompt, press **Return** to accept the default of **No**. |
| 6 | At the **Division** prompt, override the default for the main division by entering the name of another division, **Remote Clinic** for this example. |
| 7 | At the **ID Qualifier: Electronic Plan Type//** prompt, enter **Blue Shield** to override the default value for this example. |
| 8 | At the **Form Type** prompt, enter HCFA 1500 for this example. |
| 9 | At the **Billing Provider Secondary ID** prompt, enter the ID **1XXXXX1B** for this example. |
| 10 | Repeat these steps for the Form Type = **UB92**, Qualifier = **Blue Cross** and ID = **1XXXXX1A**. |

*Note: Users may repeat these steps to define different Billing Provider Secondary IDs for each division if required by the insurance company.*

```
Billing Provider IDs (Parent)       May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co: BLUE CROSS OF CALIFORNIA       Billing Provider Secondary IDs
     ID Qualifier                    ID #             Form Type
Division: Name of Main Division/Default for All Divisions
1    Blue Cross                      XXXXXX1A         UB92
2    Blue Shield                     XXXXXX1B         HCFA




          Enter ?? for more actions
    Add an ID            Additional IDs        Exit
    Edit an ID           ID Parameters
    Delete an ID         VA-Lab/Facility IDs

Select Action: Quit// a   Add ID
Define Billing Provider Secondary IDs by Care Units? No//No
Division: Main Division// Remote Clinic
ID Qualifier: Electronic Plan Type//Blue Shield
Enter Form Type for ID: HCFA 1500
Billing Provider Secondary ID: 1XXXXX1B
```

The following screen will display.

Note: The two IDs for the Remote Clinic division will be available to the clerk on Billing Screen 3 for claims for services provided by this division.

```
Billing Provider IDs          May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co: BLUE CROSS OF CALIFORNIA   Billing Provider Secondary IDs
     ID Qualifier                        ID #             Form Type
Division: Name of Main Division/Default for All Divisions
1    Blue Cross                          XXXXXX1A         UB92
2    Blue Shield                         XXXXXX1B         HCFA

Division: Remote Clinic
3    Blue Cross                          1XXXXX1A         UB92
4    Blue Shield                         1XXXXX1B         HCFA



          Enter ?? for more actions
    Add an ID            Additional IDs        Exit
    Edit an ID           ID Parameters
    Delete an ID         VA-Lab/Facility IDs

Select Action: Quit//
```

### 3.2.2.3 Define Billing Provider Secondary IDs by Division, Form Type and Care Unit

If an insurance company requires different Billing Provider Secondary IDs for services provided by particular Care Units, users can define them by Division, Form Type and Care Unit.

| Step | Procedure |
|---|---|
| 1 | Access the option **SYST→Insurance Company Entry/Edit**. |
| 2 | At the **Select Insurance Company Name**: prompt, enter **Blue Cross of California** for this example. |
| 3 | From the **Insurance Company Editor** screen, enter the action, **ID Prov IDs/ID Parameters**. |
| 4 | From the **Billing Provider IDs screen**, enter the action **Add an ID**. |
| 5 | At the **Define Billing Provider Secondary IDs by Care Units? No//** prompt, enter **YES** to override the default. |
| 6 | At the **Division** prompt, press **Return** to accept the default for the **Main Division**. |
| 7 | At the **Care Unit:** prompt, enter ?? to see a pick list of available Care Units. |
| | *Refer to **Section 3.4.2** to learn how to create this list of available Care Units.* |
| 8 | At the **Care Unit:** prompt, enter **Anesthesia** for this example. |
| 9 | At the **ID Qualifier: Electronic Plan Type//** prompt, enter **Blue Shield** to override the default value for this example. |
| 10 | At the **Form Type** prompt, enter **HCFA 1500** for this example. |
| 11 | At the **Billing Provider Secondary ID** prompt, enter the ID **11XXXX1B** for this example. |

12 Repeat these steps for the Form Type = **UB92**, Qualifier = **Blue Cross** and ID = **11XXXX1A**.

13 Repeat these steps for Care Units **Reference Lab** and **Home Health**.

```
Billing Provider IDs          May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co: BLUE CROSS OF CALIFORNIA   Billing Provider Secondary IDs
     ID Qualifier                     ID #             Form Type
Division: Name of Main Division/Default for All Divisions
1    Blue Cross                       XXXXXX1A         UB92
2    Blue Shield                      XXXXXX1B         HCFA

Division: Remote Clinic
3    Blue Cross                       1XXXXX1A         UB92
4    Blue Shield                      1XXXXX1B         HCFA


          Enter ?? for more actions
    Add an ID            Additional IDs        Exit
    Edit an ID           ID Parameters
    Delete an ID         VA-Lab/Facility IDs

Select Action: Quit// a   Add ID
Define Billing Provider Secondary IDs by Care Units? No//??

   Enter No to define a Billing Provider Secondary ID
   for the Division.
   Enter Yes to define a Billing Provider Secondary ID
   for a specific Care Unit.
   If no Care Unit is entered on Billing Screen 3, the
   Billing Provider Secondary ID defined for the Division will
   be transmitted in the claim.

       0   No
       1   Yes

Define Billing Provider Secondary IDs by Care Units? No//1  Yes
Division: Main Division// Main Division
Care Unit:??
   Select a Care Unit from the list:
       1 Anesthesia
       2 Reference Lab
       3 Home Health
Care Unit: 1   Anesthesia
ID Qualifier: Electronic Plan Type//Blue Shield
Enter Form Type for ID: HCFA 1500
Billing Provider Secondary ID: 11XXXX1B
```

The following screen will display.

```
Billing Provider IDs          May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co: BLUE CROSS OF CALIFORNIA   Billing Provider Secondary IDs
     ID Qualifier                        ID #              Form Type
Division: Name of Main Division/Default for All Divisions
1    Blue Cross                          XXXXXX1A          UB92
2    Blue Shield                         XXXXXX1B          HCFA
 Care Unit: Anesthesia
3    Blue Cross                          11XXXX1A          UB92
4    Blue Shield                         11XXXX1B          HCFA
 Care Unit: Reference Lab
5    Blue Cross                          12XXXX1A          UB92
6    Blue Shield                         12XXXX1B          HCFA
 Care Unit: Home Health
7    Blue Cross                          13XXXX1A          UB92
8    Blue Shield                         13XXXX1B          HCFA
+
          Enter ?? for more actions
    Add an ID            Additional IDs        Exit
    Edit an ID           ID Parameters
    Delete an ID         VA-Lab/Facility IDs

Select Action: Quit//
```

*If users want a default Billing Provider Secondary ID to populate Billing Screen 3, define a default ID for the division and define IDs for the division and specific care units. Users will have the ability to either accept the default ID or override it with one of the Care Unit IDs during the creation of a claim. Refer to **Section 4.1.2**.*

#### 3.2.2.4 Define Additional Billing Provider Secondary IDs by Division and Form Type

In addition to the Billing Provider Secondary ID that appears on Billing Screen 3 for each insurance company on the bill, there can be six additional Billing Provider Secondary IDs that will be transmitted with claims for an insurance company.

Prior to Patch IB*2.0*320, the IDs defined in IB Site Parameters, Section 14 and Provider ID Maintenance, Number 3, were transmitted with all claims to all payers. These options for defining IDs were removed with Patch IB*2.0*320.

If an insurance company requires additional Billing Provider Secondary IDs, users can define them in Insurance Company Entry/Edit.

| Step | Procedure |
|---|---|
| 1 | Access the option **SYST→Insurance Company Entry/Edit**. |
| 2 | At the **Select Insurance Company Name**: prompt, enter **Blue Cross of California** for this example. |
| 3 | From the **Insurance Company Editor** screen, enter the action, **ID Prov IDs/ID Parameters**. |
| 4 | From the **Billing Provider IDs screen**, enter the action **Additional IDs**. |
| 5 | From the **Billing Provider IDs – Additional Billing Provider Sec. IDs screen,** enter the action **Add an ID**. |

6 At the **ID Qualifier:** prompt, enter **Medicare** for this example.

*Note: There can not be two Billing Provider Secondary IDs on a claim with the same Qualifier. If you enter an ID with the same Qualifier here as one defined under Billing Provider Secondary IDs for the Division on a claim, the Additional Billing Provider Secondary ID with the same Qualifier will not be transmitted on the claim.*

7 At the **Form Type** prompt, enter **HCFA 1500** for this example.

9 At the **Billing Provider Secondary ID** prompt, enter the ID **14XXXX1C** for this example.

10 Repeat these steps for the Form Type = **UB92**, Qualifier = **Medicare**, ID = **14XXXX1C**.

*Note: Users may repeat these steps to define multiple additional Billing Provider Secondary IDs if required by the insurance company.*

```
Billing Provider IDs (Parent) May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co: BLUE CROSS OF CALIFORNIA  Additional Billing Provider Sec. IDs
     ID Qualifier                ID #             Form Type

No Additional Billing Provider IDs found




          Enter ?? for more actions
    Add an ID           Delete an ID     Exit
    Edit an ID          Copy IDs

Select Action: Quit// Add an ID
Type of ID: Medicare
Form Type: HCFA
Billing Provider Secondary ID: 14XXXX1C
```

The following screen will display.

```
Billing Provider IDs (Parent) May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co: BLUE CROSS OF CALIFORNIA  Additional Billing Provider Sec. IDs
     ID Qualifier                ID #             Form Type
Division: Name of Main Division/Default for All Divisions
1    Medicare                    14XXXX1C         UB92
2    Medicare                    14XXXX1C         HCFA




          Enter ?? for more actions
    Add an ID           Delete an ID     Exit
    Edit an ID          Copy IDs

Select Action: Quit// Add an ID
Type of ID: Medicare
Form Type: UB92
Billing Provider Secondary ID: XXXXXXX11
```

## 3.3. Service Facility IDs (Laboratory or Facility IDs)

The 837 claims transmission has records that contain Service Facility data like the name and address of a facility and primary and secondary IDs for that facility. Often this is a division other than the actual VAMC or an outside, non-VA facility. These IDs are called the Laboratory or Facility Primary ID and the Laboratory or Facility Secondary IDs.

If there is a non-VA facility on a claim because a veteran received care at an outside laboratory or a private hospital or clinic, an insurance company may require the claim to contain primary and secondary Laboratory or Facility IDs for the organization that provided the care.

If there is not an outside facility on a claim, but the care was provided by the VA at a facility other than the main hospital (a clinic), an insurance company may require the claim to contain primary and secondary Laboratory or Facility IDs for the clinic.

If there is not an outside facility on a claim and the care was provided by the VAMC, an insurance company may require the data for the billing provider (the VAMC) be repeated in the Service Facility record.

Some insurance companies want no data for the VAMC repeated in the Service Facility section. A new parameter has been added to the Insurance Company Editor that users can set to prevent VAMC data from being sent in the Service Facility records. Refer to **Section 3.6.4**.

Patch IB*2.0*320 provided enhancements to allow users to more easily define Laboratory or Facility IDs for the VA or non-VA.

### 3.3.1 Define Non-VA Laboratory or Facility Primary IDs

For outside, non-VA facilities such as an independent laboratory, the Laboratory or Facility Primary ID should be the entity's Federal Tax ID.

| Step | Procedure |
|---|---|
| 1 | Access the option **SYST→Provider ID Maintenance**. |
| 2 | At the **Select** : prompt, press **Return** to accept the default. |
| 3 | At the **Select Edit Option**: prompt, enter **6 Non/Other VA Provider ID Information**. |
| 4 | At the **(I)NDIVIDUAL OR (F)ACILITY?**: prompt, enter **Facility**. |
| 5 | From the **Non-VA Lab or Facility Info screen,** enter the action **Provider Info**. |
| 6 | At the **Name:** prompt, enter **IB Outside Facility** for this example. |
| 7 | At the **Steet Address:** prompt, enter **123 Westbend Street** for this example. |
| 8 | At the **Street Address Line 2**: prompt, press **Return** to leave blank. |
| 9 | At the **City** prompt, enter **Long Beach** for this example. |
| 9 | At the **Zip Code** prompt, enter **92060** for this example. |
| 10 | At the **ID Qualifier:** prompt, press **Return** to accept the default. |

11 At the **Lab or Facility Primary ID**: prompt, enter **XXXXX1456**.

12 At the **X12 Type of Facility:** prompt, enter **LI - Independent Lab** for this example.

13 At the **Mammography Certification Number**: prompt, press **Return** to leave it blank. If you know the Mammography number you can enter it here.

```
NAME: IB Outside Facility
STREET ADDRESS: 123 Westbend Street
STREET ADDRESS LINE 2:
CITY: Long Beach
STATE: CALIFORNIA
ZIP CODE: 92060
ID Qualifier: 24 - EMPLOYER'S IDENTIFICATION
X12 TYPE OF FACILITY: ??
        This is the code for the type of facility as identified in the X12
        documents.

     Choose from:
       77       SERVICE LOCATION
       FA       FACILITY
       LI       INDEPENDENT LAB
       TL       TESTING LAB
X12 TYPE OF FACILITY: LI  INDEPENDENT LAB
Mammography Certification Number:
```

The following screen will display.

```
Non-VA Lab or Facility Info  May 11, 2005@09:58:51          Page:    1 of    1


   Name: IB Outside Facility
Address: 123 Westbend Street
         Long Beach, CALIFORNIA  92060

Type of Facility: Independent Lab
      Primary ID: XXXXX1456
    ID Qualifier: Employer's Identification Number

Mammography Certification Number:









          Enter ?? for more actions
     Provider Info      Secondary ID Maint        Exit
Select Action: Quit//
```

### 3.3.2 Define Non-VA Laboratory or Facility Secondary IDs

For outside, non-VA facilities users can define multiple Laboratory or Facility Secondary IDs. These IDs can be either the facility's own IDs such as a Clinical Laboratory Improvement Amendment (CLIA) number or IDs assigned to the facility by an insurance company.

### 3.3.2.1 Define a non-VA Facility's Own Laboratory or Facility Secondary IDs

| Step | Procedure |
|---|---|
| 1 | Access the option **SYST→Provider ID Maintenance**. |
| 2 | At the **Select** : prompt, press **Return** to accept the default. |
| 3 | At the **Select Edit Option**: prompt, enter **6 Non/Other VA Provider ID Information**. |
| 4 | At the **(I)NDIVIDUAL OR (F)ACILITY?**: prompt, enter **Facility**. |
| 5 | From the **Non-VA Lab or Facility Info screen,** enter the action **Secondary ID Maint**. |
| 6 | At the **SELECT SOURCE OF ID: PROVIDER'S OWN IDS//** prompt, press **Return** to accept the default. |
| 7 | From the **Secondary Provider ID** screen, enter the action **Add Secondary ID**. |
| 8 | At the **Enter Provider ID Qualifier** prompt, enter **X5 CLIA Number** for this example. |
| 9 | At the **Form Type Applied to**: prompt, enter **HCFA 1500 FORMS ONLY** for this example. |
| 10 | At the **Care Type:** prompt, enter **OUTPATIENT ONLY** for this example. |
| 11 | At the **Enter Lab or Facility Secondary ID** prompt, enter **DXXXXX** for this example. |

*Note: Users may repeat these steps to define more Laboratory or Facility Secondary IDs.*

```
Secondary Provider ID          May 11, 2005@11:17:20          Page:    1 of    1
           ** Lab or Facility's Own IDs (No Specific Insurance Co) **

Provider: IB Outside Facility (Non-VA Lab or Facility)

       ID Qualifier                Form   Care Type                ID#
 No ID's found for provider


          Enter ?? for more actions
     Add Secondary ID            Delete Secondary ID
     Edit Secondary Id           Exit
Select Action: Quit// a   Add Secondary ID
Select Provider ID Qualifier: X5 CLIA Number
FORM TYPE APPLIED TO: HCFA 1500 FORMS ONLY
BILL CARE TYPE: OUTPATIENT ONLY

THE FOLLOWING WAS CHOSEN:
   INSURANCE: ALL INSURANCE
   PROV TYPE: CLIA #
   FORM TYPE: HCFA 1500 FORM ONLY
   CARE TYPE: OUTPATIENT ONLY

Provider ID: DXXXXX
```

The following screen will display.

```
Secondary Provider ID          May 11, 2005@11:17:20          Page:    1 of    1
           ** Lab or Facility's Own IDs (No Specific Insurance Co) **

Provider: IB Outside Facility (Non-VA Lab or Facility)

     ID Qualifier                 Form   Care Type     ID#
1    CLIA Number                  HCFA   OUTPT         DXXXXX




          Enter ?? for more actions
     Add Secondary ID            Delete Secondary ID
     Edit Secondary Id           Exit
Select Action: Quit//
```

### 3.3.2.2 Define a non-VA Facility's Laboratory or Facility Secondary IDs Assigned by an Insurance Company

| Step | Procedure |
|---|---|
| 1 | Access the option **SYST→Provider ID Maintenance**. |
| 2 | At the **Select** : prompt, press **Return** to accept the default. |
| 3 | At the **Select Edit Option**: prompt, enter **6 Non/Other VA Provider ID Information**. |
| 4 | At the **(I)NDIVIDUAL OR (F)ACILITY?**: prompt, enter **Facility**. |
| 5 | From the **Non-VA Lab or Facility Info screen,** enter the action **Secondary ID Maint**. |
| 6 | At the **SELECT SOURCE OF ID: PROVIDER'S OWN IDS//** prompt, enter **PROVIDER IDS FURNISHED BY AN INSURANCE COMPANY**. |
| 7 | From the **Secondary Provider ID** screen, enter the action **Add Secondary ID.** |
| 8 | At the **Enter Provider ID Qualifier** prompt, enter **Blue Shield** for this example. |
| 9 | At the **Form Type Applied to**: prompt, enter **HCFA 1500 FORMS ONLY** for this example. |
| 10 | At the **Care Type:** prompt, enter **BOTH** for this example. |
| 11 | At the **Enter Lab or Facility Secondary ID** prompt, enter **111XXX1B** for this example. |
| | *Note: Users may repeat these steps to define more Laboratory or Facility Secondary IDs. A maximum of 5 Laboratory or Facility Secondary IDs can be defined per insurance company. A maximum of 5 Laboratory or Facility Secondary IDs can be transmitted in a claim.* |

```
Secondary Provider ID          May 11, 2005@11:17:20          Page:    1 of    1
          ** Lab or Facility Secondary IDs from Insurance Co **

Provider: IB Outside Facility (Non-VA Lab or Facility)
Insurance Co: BLUE CROSS OF CALIFORNIA

     ID Qualifier               Form   Care Type                 ID#

  No ID's found for provider and selected insurance co




          Enter ?? for more actions
     Add Secondary ID            Delete Secondary ID
     Edit Secondary Id           Exit
Select Action: Quit// a   Add Secondary ID
Select Provider ID Qualifier: BLUE SHIELD ID
FORM TYPE APPLIED TO: HCFA FORMS ONLY
BILL CARE TYPE: b  BOTH INPATIENT AND OUTPATIENT

THE FOLLOWING WAS CHOSEN:
   INSURANCE: BLUE CROSS OF CALIFORNIA
   PROV TYPE: BLUE SHIELD ID
   FORM TYPE: HCFA FORM ONLY
   CARE TYPE: BOTH INPATIENT AND OUTPATIENT

Provider ID: 111XXX1B
```

The following screen will display.

```
Secondary Provider ID          May 11, 2005@11:17:20          Page:    1 of    1
          ** Lab or Facility Secondary IDs from Insurance Co **

Provider: IB Outside Facility (Non-VA Lab or Facility)
Insurance Co: BLUE CROSS OF CALIFORNIA

     ID Qualifier               Form   Care Type                 ID#
1    BLUE SHIELD ID             HCFA   INPT/OUTPT                111XXX1B









          Enter ?? for more actions
     Add Secondary ID            Delete Secondary ID
     Edit Secondary Id           Exit
Select Action: Quit//
```

### 3.3.3 Define VA Laboratory or Facility Primary IDs

The Laboratory or Facility Primary ID for all VA divisions is the site's Federal Tax Number. This number will be automatically retrieved from the IB Site Parameters.

### 3.3.4 Define VA Laboratory or Facility Secondary IDs

For each insurance company, users can define multiple Laboratory or Facility Secondary IDs for the VA by division and form type.

| Step | Procedure |
|---|---|
| 1 | Access the option **SYST→Insurance Company Entry/Edit**. |
| 2 | At the **Select Insurance Company Name**: prompt, enter **Blue Cross of California** for this example. |
| 3 | From the **Insurance Company Editor** screen, enter the action, **ID Prov IDs/ID Parameters**. |
| 4 | From the **Billing Provider IDs** screen, enter the action **VA-Lab/Facility IDs**. |
| 5 | From the **VA-Lab/Facility IDs** screen, enter the action **Add an ID**. |
| 6 | At the **Division** prompt, accept the default for the main Division. |
| 7 | At the **ID Qualifier:** prompt, enter **Blue Shield** to override the default value for this example. |
| 8 | At the **Form Type** prompt, enter **HCFA 1500** for this example. |
| 9 | At the **Billing Provider Secondary ID** prompt, enter the ID **1212XX1B** for this example. |
| 10 | Repeat these steps for the Form Type = **UB92**, Qualifier = **Blue Cross** and ID = **1212XX1A**. |
| 11 | Repeat these steps for the Form Type = **UB92**, Qualifier = **Commercial** and ID = **1313XXG2**. |

*Note: Users may repeat these steps to define more Laboratory or Facility Secondary IDs. A maximum of 5 Laboratory or Facility Secondary IDs can be defined per division, form and insurance company.*

```
VA-Lab/Facility IDs              May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co.: BLUE CROSS OF CALIFORNIA

VA-Lab/Facility Primary ID: XX123456

VA-Lab/Facility Secondary IDs
   ID Qualifier              ID #             Form Type

No Laboratory or Facility IDs found




          Enter ?? for more actions
    Add an ID        Delete an ID
    Edit an ID       Exit

Select Action: Add an ID
```

The following screen will display.

```
VA-Lab/Facility IDs              May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co.: BLUE CROSS OF CALIFORNIA

VA-Lab/Facility Primary ID: Federal Tax ID

VA-Lab/Facility Secondary IDs
     ID Qualifier                ID#              Form Type
Division: Name of Main Division/Default for All Divisions
1    Blue Cross                  1212XX1A         UB92
2    Blue Shield                 1212XX1B         HCFA

Division: CBOC
3    Commercial                  1313XXG2         UB92


          Enter ?? for more actions
    Add an ID        Delete an ID
    Edit an ID       Exit

Select Action: Edit//
```

## 3.4. Attending, Operating and Other Physicians and Rendering, Referring and Supervising Providers

A physician can appear on a UB92 claim form as an Attending, Operating or Other Physician. A heath care provider (physician, nurse, physical therapist, etc.) can appear on a HCFA claim form as a Rendering, Referring or Supervising Provider.

All of these health care providers have a primary ID. Their primary ID is their Social Security Number (SSN). These physicians/providers can also have multiple secondary IDs that are either their own IDs or IDs provided by an insurance company.

All of these types of health care providers can be either VA or non-VA employees.

### 3.4.1 Define VA Physician and Provider IDs

#### 3.4.1.1 Define a VA Physician/Provider's Primary ID

The VA Physician's and Provider's SSNs are defined in the New Person file (#200). These IDs should be entered when the user is originally added to the system.

#### 3.4.1.2 Define a VA Physician/Provider's Own Secondary IDs

Physicians and other health care providers are assigned IDs that identify them. These IDs include a Social Security Number which serves as their primary ID. In addition to their SSN, they may also have one or more of the following types of secondary IDs:

- OB - State License Number
- TJ – Federal Taxpayer's Number
- X5 – State Industrial Accident Provider Number
- 1G – UPIN Number

| Step | Procedure |
|---|---|
| 1 | Access the **Provider ID Maintenance** option. At the **Select Action** prompt, press **Return** to accept the default. |
| 2 | At the **Select EDIT OPTION**: prompt, enter **1**. |
| 3 | At the **Select SOURCE OF ID**: prompt, press **Return** to accept the default of **Provider's Own IDs**. |
| 4 | At the **(V)A or (N)on-VA provider: V//**: prompt, press **Return** to accept the default. |
| 5 | At the **Select V.A. PROVIDER NAME:** prompt, enter **IB,DOCTOR 1**. |

*This screen can be accessed through the **MCCR System Definition Menu.** Users must hold the **IB PROVIDER EDIT** security key to access this option.*

```
PROVIDER ID MAINTENANCE       May 27, 2005@11:01:51          Page:    1 of    1


               -- PROVIDER ID EDITS --
          1 > PROVIDER SPECIFIC IDS
              o PROVIDER'S OWN IDS
              o PROVIDER IDS FURNISHED BY INSURANCE CO
          2 > INSURANCE CO IDS

          4 > CARE UNIT MAINTENANCE
              o Care Units for Performing Provider IDs
              o Care Units for Billing Provider Secondary IDs
          5 > INS CO BATCH ID ENTRY


              -- NON/OTHER VA ENTITY EDITS --
          6 > NON/OTHER VA PROVIDER ID INFORMATION

          Enter ?? for more actions
     Select                    Exit
Select Action: Select//Select
Select EDIT OPTION:  (1-6): 1

SELECT SOURCE OF ID: PROVIDER'S OWN IDS//

(V)A or (N)on-VA provider: V// A PROVIDER
Select V.A. PROVIDER NAME:IB,DOCTOR 1
```

| Step | Procedure |
|---|---|
| 6 | At the **Select ID Qualifier:** prompt, enter **State License** for this example. |
| 7 | At the **Select LICENSING STATE**: prompt, enter **California** for this example. |
| 8 | When asked if you are entering California as the 1st state for this provider, enter **Yes**. |
| 9 | At the **LICENSING STATE**: prompt, press **Return** to accept the default. |
| 10 | At the **LICENSING NUMBER**: prompt, enter **XXXXSTATE** for this example. |

```
Physician/Provider ID                Nov 02, 2005@10:24:46          Page:    1 of    1
              ** Physician/Provider's Own IDs (No Specific Insurance Co) **
Provider    : IB,DOCTORB (VA PROVIDER)

     ID Qualifier         Form     Care Type    Care Unit       ID#

  No ID's found for provider




          Enter ?? for more actions
     Add A Provider ID                       Delete a Provider ID
     Edit Provider Id                        Exit
Select Action: Quit//
Select Action: Quit// ad   Add A Provider ID
Select ID Qualifier: ??

   Choose from:
       State License Number     OB
       Federal Taxpayer's Number     TJ
       State Industrial Accident Provider Number    X5
       UPIN    1G

Enter the Qualifier that identifies the type of ID.

Select Provider ID Type: State License
Select LICENSING STATE: CALIFORNIA
  Are you adding 'CALIFORNIA' as a new LICENSING STATE (the 1ST for this NEW PER
SON)? No// y  (Yes)
LICENSING STATE: CALIFORNIA//
LICENSE NUMBER: XXXXSTATE
```

The following screen will display.

```
Physician/Provider ID                Nov 02, 2005@10:24:46          Page:    1 of    1
              ** Physician/Provider's Own IDs (No Specific Insurance Co) **
Provider    : IB,DOCTORB (VA PROVIDER)

     ID Qualifier         Form     Care Type    Care Unit       ID#
1    CA STATE LICENSE #                                        XXXXSTATE




          Enter ?? for more actions
     Add A Provider ID                       Delete a Provider ID
     Edit Provider Id                        Exit
Select Action: Quit//
```

### 3.4.1.3 Define a VA Physician/Provider's Insurance Company Secondary IDs

Physicians and other health care providers can be assigned secondary IDs by insurance companies. Some insurance companies assign one ID to be used by every physician/provider at a site. Other insurance companies assign each physician/provider

his or her own ID. In addition to their SSN, they may also have one or more of the following types of secondary IDs:

- 1A - Blue Cross
- 1B - Blue Shield
- 1C - Medicare
- 1H - CHAMPUS
- G2 - Commercial
- LU - Location #
- N5 - Provider Plan Network

| Step | Procedure |
|---|---|
| 1 | Access the **Provider ID Maintenance** option. At the **Select Action** prompt, press **Return** to accept the default. |
| 2 | At the **Select EDIT OPTION**: prompt, enter **1**. |
| 3 | At the **Select SOURCE OF ID**: prompt, enter **PROVIDER IDS FURNISHED BY AN INSURANCE COMPANY**. |
| 4 | At the **(V)A or (N)on-VA provider: V//**: prompt, press **Return** to accept the default. |
| 5 | At the **Select V.A. PROVIDER NAME:** prompt, enter **IB,DOCTOR 1**. |
| 6 | At the **Select Insurance Co.**: prompt, enter **Blue Cross of California** for this example. |

```
PROVIDER ID MAINTENANCE       May 27, 2005@11:01:51          Page:    1 of    1


               -- PROVIDER ID EDITS --
          1 > PROVIDER SPECIFIC IDS
              o PROVIDER'S OWN IDS
              o PROVIDER IDS FURNISHED BY INSURANCE CO
          2 > INSURANCE CO IDS

          4 > CARE UNIT MAINTENANCE
              o Care Units for Performing Provider IDs
              o Care Units for Billing Provider Secondary IDs
          5 > INS CO BATCH ID ENTRY


              -- NON/OTHER VA ENTITY EDITS --
          6 > NON/OTHER VA PROVIDER ID INFORMATION

          Enter ?? for more actions
     Select                    Exit
Select Action: Select//Select
Select EDIT OPTION:  (1-6): 1

SELECT SOURCE OF ID: PROVIDER'S OWN IDS// PROVIDER IDS FURNISHED BY AN INSURANCE
COMPANY.
(V)A or (N)on-VA provider: V// A PROVIDER
Select V.A. PROVIDER NAME:IB,DOCTOR 1
Select INSURANCE CO: BLUE CROSS OF CALIFORNIA
```

| Step | Procedure |
|---|---|
| 7 | At the **Select Action**: prompt, enter **Add an ID**. |
| 8 | At the **Select ID Qualifier**: prompt, enter **1B – Blue Shield** for this example. |
| 9 | At the **FORM TYPE APPLIED TO**: prompt, enter **HCFA 1500 Only** for this example. |
| 10 | At the **BILL CARE TYPE**: prompt, enter **0** for this example. |
| 11 | At the **CARE UNIT**: prompt, enter **Surgery** for this example. |
| 12 | At the **PROVIDER ID**: prompt, enter **XXXXBSHIELD** for this example. |

*Defining an insurance company provided ID for a particular Care Unit is only necessary when the insurance company assigns physician/provider IDs by care unit.*

*Users can repeat these steps for this Physician/Provider adding more IDs from this insurance company or change insurance company or change physician/provider. Refer to **Section 3.7** to learn about copying IDs to multiple insurance companies.*

*Note: If you do not define a **Network ID** for **TRICARE** claims, the system will automatically include the provider's **SSN** as the Network ID.*

```
Physician/Provider ID                Nov 02, 2005@10:24:46          Page:    1 of    1
              ** Physician/Provider's IDs from Insurance Co **
Provider    : IB,DOCTORB (VA PROVIDER)
INSURANCE CO: BLUE CROSS OF CALIFORNIA (Parent)

     ID Qualifier         Form     Care Type    Care Unit       ID#
  No ID's found for provider


          Enter ?? for more actions
     Add an ID              Delete an ID        Copy IDs/All Prov
     Edit an ID             Copy IDs/Prov       Exit
Select Action: Quit// ad   Add an ID
Select ID Qualifier: ??
   Choose from:
      1A - Blue Cross
      1B - Blue Shield
      1C - Medicare
      1H - CHAMPUS
      G2 - Commercial
      LU - Location #
      N5 - Provider Plan Network
Enter the Qualifier that identifies the type of ID.

Select Provider ID Type: Blue Shield
FORM TYPE APPLIED TO: HCFA 1500 FORMS ONLY
BILL CARE TYPE: 0  BOTH INPATIENT AND OUTPATIENT
Select IB PROVIDER ID CARE UNIT: Surgery

THE FOLLOWING WAS CHOSEN:
   INSURANCE: BLUE CROSS OF CALIFORNIA
   PROV TYPE: BLUE SHIELD ID
   FORM TYPE: HCFA 1500 FORM ONLY
   CARE TYPE: BOTH INPATIENT AND OUTPATIENT
   CARE UNIT: Surgery

PROVIDER ID: XXXXBSHIELD
```

The following screen will display.

```
Physician/Provider ID                Nov 02, 2005@10:24:46          Page:    1 of    1
             ** Physician/Provider's IDs from Insurance Co **
Provider    : IB,DOCTORB (VA PROVIDER)
INSURANCE CO: BLUE CROSS OF CALIFORNIA (Parent)

     ID Qualifier          Form   Care Type    Care Unit       ID#
1    BLUE SHIELD ID        HCFA   INPT/OUTPT                   XXXXBSHIELD




          Enter ?? for more actions
     Add an ID              Delete an ID        Copy IDs/All Prov
     Edit an ID             Copy IDs/Prov       Exit
Select Action: Quit//
```

### 3.4.2 Define non-VA Physician and Provider IDs

#### 3.4.2.1 Define a non-VA Physician/Provider's Primary ID

Non-VA physicians and other health care providers are not VistA users so they are not in the New Person file. Non-VA physician/provider primary and secondary IDs are both defined the same way and the system knows to look for and use the SSN as the primary ID. Refer to the following section.

*Note: Non-VA Physician/Provider IDs can be defined through Provider ID Maintenance through **1 > PROVIDER SPECIFIC IDS** or through **6 > NON/OTHER VA PROVIDER ID INFORMATION.***

#### 3.4.2.2 Define a non-VA Physician/Provider's Own IDs

Non-VA Physicians and other health care providers are assigned IDs that identify them. These IDs include a Social Security Number which serves as a primary ID. In addition to their SSN, they may also have one or more of the following types of secondary IDs:

- OB - State License Number
- TJ – Federal Taxpayer's Number
- X5 – State Industrial Accident Provider Number
- 1G - UPIN

| Step | Procedure |
|---|---|
| 1 | Access the **Provider ID Maintenance** option. At the **Select Action** prompt, press **Return** to accept the default. |
| 2 | At the **Select EDIT OPTION**: prompt, enter **1**. |
| 3 | At the **Select SOURCE OF ID**: prompt, press **Return** to accept the default of **Provider's Own IDs**. |
| 4 | At the **(V)A or (N)on-VA provider: V//**: prompt, enter **N** for Non-VA provider. |
| 5 | At the **Select Non V.A. PROVIDER NAME:** prompt, enter **IB,OUTSIDEDOC** for this example. |

*Users must hold the **IB PROVIDER EDIT** security key to access this option.*

*Note: For non-VA physicians and provider, be sure to define an SSN with the Qualifier SY as this will be used as the Attending, Operating, Other, Rendering, Referring or Supervising primary ID.*

```
PROVIDER ID MAINTENANCE       May 27, 2005@11:01:51          Page:    1 of    1


               -- PROVIDER ID EDITS --
          1 > PROVIDER SPECIFIC IDS
              o PROVIDER'S OWN IDS
              o PROVIDER IDS FURNISHED BY INSURANCE CO
          2 > INSURANCE CO IDS

          4 > CARE UNIT MAINTENANCE
              o Care Units for Performing Provider IDs
              o Care Units for Billing Provider Secondary IDs
          5 > INS CO BATCH ID ENTRY


              -- NON/OTHER VA ENTITY EDITS --
          6 > NON/OTHER VA PROVIDER ID INFORMATION

          Enter ?? for more actions
     Select                      Exit
Select Action: Select//Select
Select EDIT OPTION:  (1-6): 1

SELECT SOURCE OF ID: PROVIDER'S OWN IDS//

(V)A or (N)on-VA provider: V//  n  NON-VA PROVIDER
Select Non V.A. PROVIDER NAME:IB,OUTSIDEDOC
```

| Step | Procedure |
|---|---|
| 6 | At the **Select ID Qualifier:** prompt, enter **Social Security Number** for this example. |
| 7 | At the **FORM TYPE APPLIED TO**: prompt, enter **0** for this example. |
| 8 | At the **BILL CARE TYPE**: prompt, enter **0** for this example. |
| 9 | At the **PROVIDER ID**: prompt, enter **XXXXX1212** for this example. |
| | Note: Users may repeat the above steps to enter additional IDs for a physician/provider. |

```
Physician/Provider ID                Nov 02, 2005@10:24:46          Page:    1 of    1
              ** Physician/Provider's Own IDs (No Specific Insurance Co) **
Provider    : IB,OUTSIDEDOC (NON-VA PROVIDER)

     ID Qualifier         Form     Care Type    Care Unit       ID#

  No ID's found for provider




          Enter ?? for more actions
     Add A Provider ID                       Delete a Provider ID
     Edit Provider Id                        Exit
Select Action: Quit//
Select Action: Quit// ad   Add A Provider ID
Select ID Qualifier: ??

   Choose from:
       State License Number     OB
       Federal Taxpayer's Number     TJ
       State Industrial Accident Provider Number     X5
       Social Security Number     SY
       UPIN     1G

Enter the Qualifier that identifies the type of ID.

Select ID Qualifier: Social Security Number
FORM TYPE APPLIED TO: 0  BOTH UB92 AND HCFA 1500 FORMS
BILL CARE TYPE: 0  BOTH INPATIENT AND OUTPATIENT

THE FOLLOWING WAS CHOSEN:
   INSURANCE: ALL INSURANCE
   PROV TYPE: SOCIAL SECURITY NUMBER
   FORM TYPE: BOTH UB92 & HCFA 1500 FORMS
   CARE TYPE: BOTH INPATIENT AND OUTPATIENT

PROVIDER ID: XXXXX1212
```

The following screen will display.

```
Physician/Provider ID                Nov 02, 2005@10:24:46          Page:    1 of    1
              ** Physician/Provider's Own IDs (No Specific Insurance Co) **
Provider    : IB,OUTSIDEDOC (NON-VA PROVIDER)

     ID Qualifier         Form     Care Type    Care Unit       ID#
1    SOCIAL SECURITY NUMB  BOTH    INPT/OUTPT                   XXXXX1212




          Enter ?? for more actions
     Add A Provider ID                       Delete a Provider ID
     Edit Provider Id                        Exit
Select Action: Quit//
```

### 3.4.2.3 Define a non-VA Physician/Provider's Insurance Company Secondary IDs

Physicians and other health care providers are assigned secondary IDs by insurance companies. In addition to their SSN, they may also have one or more of the following types of secondary IDs:

- 1A - Blue Cross
- 1B - Blue Shield
- 1C - Medicare
- 1G - UPIN
- 1H - CHAMPUS
- G2 - Commercial
- LU - Location #
- N5 - Provider Plan Network

| Step | Procedure |
|---|---|
| 1 | Access the **Provider ID Maintenance** option. At the **Select Action** prompt, press **Return** to accept the default. |
| 2 | At the **Select EDIT OPTION**: prompt, enter **1**. |
| 3 | At the **Select SOURCE OF ID**: prompt, enter **PROVIDER IDS FURNISHED BY AN INSURANCE COMPANY**. |
| 4 | At the **(V)A or (N)on-VA provider: V//**: prompt, enter **N** for Non-VA provider. |
| 5 | At the **Select V.A. PROVIDER NAME:** prompt, enter **IB,OUTSIDEDOC**. |
| 6 | At the Select Insurance Co.: prompt, enter **Blue Cross of California** for this example. |

```
PROVIDER ID MAINTENANCE       May 27, 2005@11:01:51          Page:    1 of    1

                -- PROVIDER ID EDITS --
          1 > PROVIDER SPECIFIC IDS
              o PROVIDER'S OWN IDS
              o PROVIDER IDS FURNISHED BY INSURANCE CO
          2 > INSURANCE CO IDS

          4 > CARE UNIT MAINTENANCE
              o Care Units for Performing Provider IDs
              o Care Units for Billing Provider Secondary IDs
          5 > INS CO BATCH ID ENTRY

              -- NON/OTHER VA ENTITY EDITS --
          6 > NON/OTHER VA PROVIDER ID INFORMATION

          Enter ?? for more actions
     Select                    Exit
Select Action: Select//Select
Select EDIT OPTION:  (1-6): 1

SELECT SOURCE OF ID: PROVIDER'S OWN IDS// PROVIDER IDS FURNISHED BY AN INSURANCE
COMPANY.
(V)A or (N)on-VA provider: V// N Non-VA PROVIDER
Select V.A. PROVIDER NAME:IB,OUTSIDEDOC
Select INSURANCE CO: BLUE CROSS OF CALIFORNIA
```

| Step | Procedure |
|---|---|
| 7 | At the **Select Action**: prompt, enter **Add an ID**. |
| 8 | At the **Select ID Qualifier**: prompt, enter **1B – Blue Shield** for this example. |
| 9 | At the **FORM TYPE APPLIED TO**: prompt, enter **HCFA 1500 Only** for this example. |
| 10 | At the **BILL CARE TYPE**: prompt, enter **0** for this example. |
| 11 | At the **PROVIDER ID**: prompt, enter **XXBSHIELD** for this example. |

*Users can repeat these steps for this Physician/Provider adding more IDs from this insurance company or change insurance company or change physician/provider.*

```
Physician/Provider ID                Nov 02, 2005@10:24:46          Page:    1 of    1
              ** Physician/Provider's IDs from Insurance Co **
Provider    : IB,OUTSIDEDOC (Non-VA PROVIDER)
INSURANCE CO: BLUE CROSS OF CALIFORNIA (Parent)

     ID Qualifier         Form     Care Type    Care Unit       ID#

  No ID's found for provider



          Enter ?? for more actions
     Add an ID               Delete an ID
     Edit an ID              Exit
Select Action: Quit// ad   Add an ID
Select ID Qualifier: ??

   Choose from:
       1A - Blue Cross
       1B - Blue Shield
       1C - Medicare
       1G - UPIN
       1H - CHAMPUS
       G2 - Commercial
       LU - Location #
       N5 - Provider Plan Network

Enter the Qualifier that identifies the type of ID.

Select Provider ID Type: Blue Shield
FORM TYPE APPLIED TO: HCFA 1500 FORMS ONLY
BILL CARE TYPE: 0  BOTH INPATIENT AND OUTPATIENT

THE FOLLOWING WAS CHOSEN:
   INSURANCE: BLUE CROSS OF CALIFORNIA
   PROV TYPE: BLUE SHIELD ID
   FORM TYPE: HCFA 1500 FORM ONLY
   CARE TYPE: BOTH INPATIENT AND OUTPATIENT
PROVIDER ID: XXBSHIELD
```

The following screen will display.

```
Physician/Provider ID                Nov 02, 2005@10:24:46          Page:    1 of    1
              ** Physician/Provider's IDs from Insurance Co **
Provider    : IB,OUTSIDEDOC (Non-VA PROVIDER)
INSURANCE CO: BLUE CROSS OF CALIFORNIA (Parent)

     ID Qualifier          Form   Care Type    Care Unit       ID#
1    BLUE SHIELD ID        HCFA   INPT/OUTPT                   XXXXBSHIELD




          Enter ?? for more actions
     Add an ID              Delete an ID       Exit
     Edit an ID             Copy IDs
Select Action: Quit//
```

### 3.4.3 Insurance Company IDs

Both individual Physician/Provider secondary IDs and insurance company default Physician/Provider secondary IDs provided by an insurance company can be entered and copied from within Insurance Company IDs.

There are 3 options:

- I – Individual IDs
- A – Individual and Default IDs
- D – Default IDs

Option A is the basically the same as I and D combined so users can add Physician/Provider secondary IDs and/or default secondary IDs.

#### 3.4.3.1 Define Default Physician/Provider Insurance Company Secondary IDs

Users can use the Provider ID Maintenance option, Insurance Company IDs, to enter numbers that are assigned by an insurance company to be used as default Attending, Operating, Other, Rendering, Referring and Supervising Secondary IDs for all physicians and health care providers. These IDs with be automatically sent with all 837 claims to the insurance company for which the default IDs are defined.

| Step | Procedure |
|---|---|
| 1 | Access the **Provider ID Maintenance** screen. |
| 2 | At the **Select Action**: prompt, press **Return** to accept the default. |
| 3 | At the **Select Edit Option**: prompt, enter **2**. |
| 4 | At the **Select Insurance Company Name**: prompt, enter **Blue Cross of California** for this example. |
| 5 | At the **Select Display Content**: prompt, enter **D**. |

```
Provider ID Maintenance       Dec 15, 2005@15:35:53          Page:    1 of    1


                -- PROVIDER ID EDITS --
         1 > PROVIDER SPECIFIC IDS
             o PROVIDER'S OWN IDS
             o PROVIDER IDS FURNISHED BY INSURANCE CO
         2 > INSURANCE CO IDS

         4 > CARE UNIT MAINTENANCE
             o Care Units for Performing Provider IDs
             o Care Units for Billing Provider Secondary IDs
         5 > INS CO BATCH ID ENTRY


             -- NON/OTHER VA ENTITY EDITS --
         6 > NON/OTHER VA PROVIDER ID INFORMATION

         Enter ?? for more actions
     Select                    Exit
Select Action: Quit// s   Select
Select EDIT OPTION:  (1-6): 2
Select INSURANCE COMPANY NAME:  BLUE CROSS OF CALIFORNIA     PO BOX 60007         LOS
ANGELES     CALIFORNIA       Y
SELECT DISPLAY CONTENT: A//D  INSURANCE CO DEFAULT IDS
```

| Step | Procedure |
|---|---|
| 5 | At the **Select Action**: prompt, enter **Add an ID Record**. |

```
INSURANCE CO PROVIDER ID      Dec 19, 2005@12:24:41          Page:    1 of    2
Insurance Co: BLUE CROSS OF CALIFORNIA (Parent)
     PROVIDER NAME         FORM   CARE TYPE    CARE UNIT       ID#


Provider ID Type: BLUE SHIELD
1    <<INS CO DEFAULT>>    BOTH   INPT/OUTPT                    BSDEFAULT

Provider ID Type: COMMERCIAL
2    <<INS CO DEFAULT>>    BOTH   INPT/OUTPT                    COMDEFAULT

Provider ID Type: PROVIDER PLAN NETWORK
3    <<INS CO DEFAULT>>    BOTH   INPT/OUTPT                    NETDEFAULT

Provider ID Type: UPIN
4    <<INS CO DEFAULT>>    BOTH   INPT/OUTPT                    UPINDEFAULT

+         Enter ?? for more actions
     Add an ID Record          Change Insurance Co       Copy IDs/Ins co
     Delete an ID Record       Change Display Format     Exit
     Edit an ID Record         Move Around in List
     Display Ins Co Params     Care Unit Maintenance
Select Action: Next Screen// Add an ID Record

Select Action: Next Screen//a   Add an ID Record
```

| Step | Procedure |
|---|---|
| 6 | At the **Select Provider (optional):** prompt, press **Return** to leave the prompt |

blank.

7 At the **YOU ARE ADDING A PROVIDER ID THAT WILL BE THE INSURANCE CO DEFAULT IS THIS OK?:** prompt, enter **YES**.

8 At the **Select Provider ID Type:** prompt, enter **Blue Cross** for this example.

9 At the **FORM TYPE APPLIED TO:** prompt, enter **UB92 Forms Only** for this example.

10 At the **BILL CARE TYPE:** prompt, enter **0** for BOTH INPATIENT AND OUTPATIENT for this example.

11 At the **PROVIDER ID:** prompt, enter **BCDEFAULT** for this example.

```
YOU ARE ADDING A PROVIDER ID THAT WILL BE THE INSURANCE CO DEFAULT


Select Provider ID Type: BLUE CROSS     1A

FORM TYPE APPLIED TO: UB92// UB92 FORMS ONLY
BILL CARE TYPE: 0  BOTH INPATIENT AND OUTPATIENT

THE FOLLOWING WAS CHOSEN:
   INSURANCE: BLUE CROSS OF CALIFORNIA
   PROV TYPE: BLUE CROSS
   FORM TYPE: UB92 FORM ONLY
   CARE TYPE: BOTH INPATIENT AND OUTPATIENT

PROVIDER ID: BCDEFAULT
```

The following screen will display.

```
INSURANCE CO PROVIDER ID      Dec 19, 2005@12:34:01          Page:    1 of    2
Insurance Co: BLUE CROSS OF CALIFORNIA (Parent)
PROVIDER NAME         FORM   CARE TYPE    CARE UNIT       ID#

Provider ID Type: BLUE CROSS
1    <<INS CO DEFAULT>>    UB-92  INPT/OUTPT                    BCDEFAULT

Provider ID Type: BLUE SHIELD
2    <<INS CO DEFAULT>>    BOTH   INPT/OUTPT                    DEFALLProv

Provider ID Type: COMMERCIAL
3    <<INS CO DEFAULT>>    BOTH   INPT/OUTPT                    COMDEFAULT

Provider ID Type: PROVIDER PLAN NETWORK
4    <<INS CO DEFAULT>>    BOTH   INPT/OUTPT                    NETDEFAULT

+         Enter ?? for more actions
     Add an ID Record          Change Insurance Co       Copy IDs
     Delete an ID Record       Change Display Format     Exit
     Edit an ID Record         Move Around in List
     Display Ins Co Params     Care Unit Maintenance
Select Action: Next Screen//
```

*Note: This default ID will be transmitted on all claims where Blue Cross of California is the payer as a Physician/Provider secondary ID.*

### 3.4.3.2 Define Individual Physician/Provider Insurance Company Secondary IDs

Users can use the Provider ID Maintenance option, Insurance Company IDs, to enter numbers that are assigned by an insurance company as individual Attending, Operating, Other, Rendering, Referring and Supervising Secondary IDs.

| Step | Procedure |
|---|---|
| 1 | Access **Provider ID Maintenance**. |
| 2 | At the **Select Action**: prompt, enter **Select**. |
| 3 | At the **Select Edit Option**: prompt, enter **2**. |
| 4 | At the **Select Insurance Company Name**: prompt, enter **Blue Cross of California** for this example (the Parent company). |

```
Provider ID Maintenance       Dec 15, 2005@15:35:53          Page:    1 of    1


                -- PROVIDER ID EDITS --
          1 > PROVIDER SPECIFIC IDS
              o PROVIDER'S OWN IDS
              o PROVIDER IDS FURNISHED BY INSURANCE CO
          2 > INSURANCE CO IDS

          4 > CARE UNIT MAINTENANCE
              o Care Units for Performing Provider IDs
              o Care Units for Billing Provider Secondary IDs
          5 > INS CO BATCH ID ENTRY


              -- NON/OTHER VA ENTITY EDITS --
          6 > NON/OTHER VA PROVIDER ID INFORMATION

          Enter ?? for more actions
     Select                     Exit
Select Action: Quit// s   Select
Select EDIT OPTION:  (1-6): 2
Select INSURANCE COMPANY NAME:  BLUE CROSS OF CALIFORNIA     PO BOX 60007          LOS
ANGELES     CALIFORNIA       Y
```

| Step | Procedure |
|---|---|
| 5 | At the **Select Display Content**: prompt, enter **I** for this example. |
| 6 | At the **Do you want to display IDs for a Specific Provider**: prompt, enter **No** for this example. |

```
SELECT DISPLAY CONTENT: A// ??

(D) DISPLAY CONTAINS ONLY THOSE IDS ASSIGNED AS DEFAULTS TO THE FACILITY BY
    THE INSURANCE COMPANY
(I) DISPLAY CONTAINS ONLY THOSE IDS ASSIGNED TO INDIVIDUAL PROVIDERS BY THE
    INSURANCE COMPANY
(A) DISPLAY CONTAINS ALL IDS ASSIGNED BY THE INSURANCE COMPANY FOR ONE OR ALL PROVIDER
ID TYPES

     Select one of the following:

          D         INSURANCE CO DEFAULT IDS
          I         INDIVIDUAL PROVIDER IDS FURNISHED BY THE INS CO
          A         ALL IDS FURNISHED BY THE INS CO BY PROVIDER TYPE

SELECT DISPLAY CONTENT: A// I  INDIVIDUAL PROVIDER IDS FURNISHED BY THE INS CO

DO YOU WANT TO DISPLAY IDS FOR A SPECIFIC PROVIDER?: NO//
```

| Step | Procedure |
|---|---|
| 7 | At the **Select Action**: prompt, enter **Add an ID Record**. |

```
INSURANCE CO PROVIDER ID      Dec 15, 2005@15:36:31          Page:    1 of   89
Insurance Co: BLUE CROSS OF CALIFORNIA (Parent)
  PERFORMING PROV ID MAY REQUIRE CARE UNIT

     PROVIDER ID TYPE      FORM   CARE TYPE    CARE UNIT       ID#

Provider: IB,DOCTOR3
1    PROVIDER PLAN NETWOR  BOTH   INPT/OUTPT                   MDXXXXXA

Provider: IB,DOCTOR9
2    PROVIDER PLAN NETWOR  BOTH   INPT/OUTPT                   GXXXXXA

Provider: IB,DOCTOR10
3    PROVIDER PLAN NETWOR  BOTH   INPT/OUTPT                   GXXXXXX

Provider: IB,DOCTOR76
4    PROVIDER PLAN NETWOR  BOTH   INPT/OUTPT                   GXXXXXX

+         Enter ?? for more actions
     Add an ID Record          Change Insurance Co       Copy IDs
     Delete an ID Record       Change Display Format     Exit
     Edit an ID Record         Move Around in List
     Display Ins Co Params     Care Unit Maintenance
Select Action: Next Screen// a   Add an ID Record
```

| Step | Procedure |
|---|---|
| 8 | At the **Select ID Qualifier**: prompt, enter **1B – Blue Shield** for this example. |
| 9 | At the **FORM TYPE APPLIED TO**: prompt, enter **HCFA 1500 Only** for this example. |
| 10 | At the **BILL CARE TYPE**: prompt, enter **0** for this example. |
| 11 | At the **CARE UNIT**: prompt, enter **Surgery** for this example. |
| 12 | At the **PROVIDER ID**: prompt, enter **BSXXXXX** for this example. |

```
Select PROVIDER: IB,DOCTOR7

Select Provider ID Type:  BLUE SHIELD      1B

FORM TYPE APPLIED TO: HCFA 1500 FORMS ONLY
BILL CARE TYPE: 0  BOTH INPATIENT AND OUTPATIENT
Select IB PROVIDER ID CARE UNIT: Surgery

THE FOLLOWING WAS CHOSEN:
   INSURANCE: BLUE CROSS OF CALIFORNIA
   PROV TYPE: BLUE SHIELD
   FORM TYPE: HCFA 1500 FORM ONLY
   CARE TYPE: BOTH INPATIENT AND OUTPATIENT
   CARE UNIT: Surgery

PROVIDER ID: BSXXXXX
```

The following screen will display.

```
INSURANCE CO PROVIDER ID      Dec 15, 2005@16:11:31          Page:   49 of   89
Insurance Co: BLUE CROSS OF CALIFORNIA (Parent)
  PERFORMING PROV ID MAY REQUIRE CARE UNIT

     PROVIDER ID TYPE      FORM   CARE TYPE    CARE UNIT       ID#
+

Provider: IB,DOCTOR15
194  PROVIDER PLAN NETWOR  BOTH   INPT/OUTPT                   GXXXXX

Provider: IB,DOCTOR54
195  PROVIDER PLAN NETWOR  BOTH   INPT/OUTPT                   G4XXXXX

Provider: IB,DOCTOR7
196  BLUE CROSS            UB-92  INPT/OUTPT                   BCXXXXXX2
197  BLUE SHIELD           HCFA   INPT/OUTPT    Surgery        BSXXXXX

Provider: IB,DOCTOR6
+         Enter ?? for more actions
     Add an ID Record          Change Insurance Co       Copy IDs
     Delete an ID Record       Change Display Format     Exit
     Edit an ID Record         Move Around in List
     Display Ins Co Params     Care Unit Maintenance
Select Action: Next Screen//
```

### 3.4.4 Define either a Default or Individual Physician/Provider Secondary ID

| Step | Procedure |
|---|---|
| 1 | Access **Provider ID Maintenance**. |
| 2 | At the **Select Action**: prompt, enter **Select**. |
| 3 | At the **Select Edit Option**: prompt, enter **2**. |
| 4 | At the **Select Insurance Company Name**: prompt, enter **Blue Cross of California** for this example (the Parent company). |
| 5 | At the **Select Display Content**: prompt, enter **A** for this example. |
| 6 | At the **DO YOU WANT TO DISPLAY IDS FOR A SPECIFIC PROVIDER ID TYPE?: NO//** prompt, accept the default. |

```
Provider ID Maintenance       Dec 15, 2005@16:17:47          Page:    1 of    1


                  -- PROVIDER ID EDITS --
          1 > PROVIDER SPECIFIC IDS
              o PROVIDER'S OWN IDS
              o PROVIDER IDS FURNISHED BY INSURANCE CO
          2 > INSURANCE CO IDS

          4 > CARE UNIT MAINTENANCE
              o Care Units for Performing Provider IDs
              o Care Units for Billing Provider Secondary IDs
          5 > INS CO BATCH ID ENTRY

              -- NON/OTHER VA ENTITY EDITS --
          6 > NON/OTHER VA PROVIDER ID INFORMATION

          Enter ?? for more actions
     Select                    Exit
Select Action: Quit// s   Select
Select EDIT OPTION:  (1-6): 2
Select INSURANCE COMPANY NAME:    BLUE CROSS OF CALIFORNIA     PO BOX 60007
    LOS ANGELES     CALIFORNIA       Y

SELECT DISPLAY CONTENT: A// LL IDS FURNISHED BY THE INS CO BY PROVIDER TYPE

DO YOU WANT TO DISPLAY IDS FOR A SPECIFIC PROVIDER ID TYPE?: NO/
```

| Step | Procedure |
|---|---|
| 7 | At the **Select Action**: prompt, enter **Add an ID Record**. |

```
INSURANCE CO PROVIDER ID      Dec 15, 2005@16:18:07          Page:    1 of   31
Insurance Co: BLUE CROSS OF CALIFORNIA (Parent)
  PERFORMING PROV ID MAY REQUIRE CARE UNIT

     PROVIDER NAME         FORM   CARE TYPE    CARE UNIT       ID#

Provider ID Type: BLUE CROSS
1    IB,DOCTOR7            UB-92  INPT/OUTPT                   BCXXXXX

Provider ID Type: BLUE SHIELD
2    <<INS CO DEFAULT>>    BOTH   INPT/OUTPT                   DEFALLProv
3    IB Outside Facility   BOTH   INPT/OUTPT                   BSFACXXXX
4    IB,DOCTOR8            BOTH   INPT/OUTPT                   BSINDOUT
5    IB,DOCTOR33           BOTH   INPT/OUTPT                   BSLIM
6    IB,DOCTOR7            HCFA   INPT/OUTPT                   BSXXXXX

Provider ID Type: PROVIDER PLAN NETWORK
7    IB,DOCTOR64           BOTH   INPT/OUTPT                   MD22356A
+         Enter ?? for more actions
     Add an ID Record          Change Insurance Co       Copy IDs/Ins co
     Delete an ID Record       Change Display Format     Exit
     Edit an ID Record         Move Around in List
     Display Ins Co Params     Care Unit Maintenance
Select Action: Next Screen//Add an ID Record
```

| Step | Procedure |
|---|---|

*At the Select Provider (optional) prompt, enter a Provider's Name to enter an individual ID or leave it blank to enter a default ID and then continue to define the ID as before.*

```
Select PROVIDER (optional): IB,DOCTOR7

     Searching for a VA PROVIDER
  IB,DOCTOR7     1XXXX     LZZ     114     RESIDENT PHYSICIAN
        ...OK? Yes//   (Yes)


Select Provider ID Type: COMMERCIAL        G2

FORM TYPE APPLIED TO: 0  BOTH UB92 AND HCFA 1500 FORMS
BILL CARE TYPE: 0  BOTH INPATIENT AND OUTPATIENT

THE FOLLOWING WAS CHOSEN:
   INSURANCE: BLUE CROSS OF CALIFORNIA
   PROV TYPE: COMMERCIAL
   FORM TYPE: BOTH UB92 & HCFA 1500 FORMS
   CARE TYPE: BOTH INPATIENT AND OUTPATIENT

PROVIDER ID: CMXXXXXX
```

## 3.5. Care Units

Some insurance companies assign the same IDs to multiple Physician/Providers, based upon Care Units, to be used as *Physician/Provider Secondary IDs* on claims. This allows more than one person to have the same ID without everyone having the same ID.

Example: Insurance Company A assigns the number XXXXXX1 to a care unit called Care Unit A and assigns this number and care unit to Dr. A, Dr. B, Dr. C and Dr. E. as their Physician/Provider Secondary ID. The same insurance company assigns the number XXXXXX2 to a care unit called Care Unit B and assigns this number and care unit to Dr. F, Dr. G, Dr. H and Dr. I. as their Physician/Provider Secondary IDs.

Some insurance companies assign IDs to be used as *Billing Provider Secondary IDs* on claims for services performed for specific types of care.

Example: Insurance Company A assigns the number XXXXHH to be used as the Billing Provider Secondary ID (Billing Screen 3) when Home Health services are provided. The same insurance company assigns the number XXXXER as the Billing Provider Secondary ID (Billing Screen 3) when Emergency services are provided.

The names of the "care unit" used by insurance companies are specified by the insurance companies and do not relate directly to the medical services or departments of the medical center. For this reason, users must define these Care Units in Provider ID Maintenance.

### 3.5.1 Define Care Units for Physician/Provider Secondary IDs

| Step | Procedure |
|---|---|
| 1 | Access the **Provider ID Maintenance** screen. |
| 2 | At the **Select Action**: prompt, press **Return** to accept the default. |
| 3 | At the **Select EDIT OPTION**: prompt, enter **4** - **Care Unit Maintenance**. |
| 4 | At the **Enter Type of Care Unit:** prompt, press **Return** to accept the default of **Care Units for Performing Provider IDs**. |
| 5 | At the **Select INSURANCE CO**: prompt, enter **Blue Cross of California** for this example. |

```
PROVIDER ID MAINTENANCE       May 27, 2005@11:01:51          Page:    1 of    1



                -- PROVIDER ID EDITS --
          1 > PROVIDER SPECIFIC IDS
              o PROVIDER'S OWN IDS
              o PROVIDER IDS FURNISHED BY INSURANCE CO
          2 > INSURANCE CO IDS

          4 > CARE UNIT MAINTENANCE
              o Care Units for Performing Provider IDs
              o Care Units for Billing Provider Secondary IDs
          5 > INS CO BATCH ID ENTRY


              -- NON/OTHER VA ENTITY EDITS --
          6 > NON/OTHER VA PROVIDER ID INFORMATION


           Enter ?? for more actions
     Select                      Exit
Select Action: Select//Select
Select EDIT OPTION:  (1-6): 4
Enter Type of Care Unit: Care Units for Performing Provider IDs//??
     1   Care Units for Performing Provider IDs
     2   Care Units for Billing Provider Secondary IDs
Choose 1-2: 1 Care Units for Performing Provider IDs
Select INSURANCE CO: Blue Cross of California
```

| Step | Procedure |
|---|---|
| 6 | At the **Select Action**: prompt, enter **Add**. |
| 7 | At the **SELECT CARE UNIT FOR THE INSURANCE CO**: prompt, enter Surgery for this example. Confirm Surgery. |
| 8 | At the **IB PROVIDER ID CARE UNIT DESCRIPTION**: prompt, enter a free text description of the Care Unit. |
| 9 | At the **ID Qualifier**: prompt, enter **Blue Shield** for this example. |
| 10 | At the **FORM TYPE APPLIED TO**: prompt, enter **0** for **BOTH UB92 & HCFA 1500 FORMS**. |
| 11 | At the **BILL CARE TYPE**: prompt, enter **0** for **BOTH INPATIENT AND OUTPATIENT**. |

*Remember, 'Blue Cross' ID can only be used on Institutional claims.*

```
PROVIDER ID CARE UNITS        Nov 03, 2005@11:56:45          Page:    1 of    1

Insurance Co: BLUE CROSS OF CALIFORNIA

    CARE UNIT NAME                  DESCRIPTION
No CARE UNITs Found for Insurance Co


          Enter ?? for more actions
     Add                                    Exit
     Edit/Delete
Select Action: Quit// a   Add
SELECT CARE UNIT FOR THE INSURANCE CO: Surgery
  Are you adding 'Surgery' as a new IB PROVIDER ID CARE UNIT? No// y  (Yes)
   IB PROVIDER ID CARE UNIT DESCRIPTION: Ambulatory Surgery

ID TYPE: BLUE SHIELD
FORM TYPE APPLIED TO: 0  BOTH UB92 & HCFA 1500 FORMS
BILL CARE TYPE: 0  BOTH INPATIENT AND OUTPATIENT
CARE UNIT: Surgery

  >> CARE UNIT COMBINATION FILED FOR THE INSURANCE CO
PRESS ENTER TO CONTINUE
```

The following screen will display.

```
PROVIDER ID CARE UNITS        Nov 03, 2005@11:56:45          Page:    1 of    1

Insurance Co: BLUE CROSS OF CALIFORNIA

    CARE UNIT NAME                  DESCRIPTION
1   Surgery                         Ambulatory Surgery
                            o BLUE SHIELD ID        Both form types  Inpt/Outpt




          Enter ?? for more actions
     Add                                    Exit
     Edit/Delete
Select Action: Quit//
```

*Once you have defined a Care Unit, when you go to define physician/provider's IDs furnished by an insurance company, you will be prompted to enter the name of the Care Unit if you enter the same ID Qualifier, Form Type and Bill Care Type as those for which you previously defined a Care Unit.*

```
PROVIDER ID                    Nov 21, 2005@09:52:39          Page:    1 of    1
                  ** Provider IDs Furnished by Insurance Co **
PROVIDER    : IB,DOCTOR7 (VA PROVIDER)
INSURANCE CO: BLUE CROSS OF CALIFORNIA
     PROVIDER ID TYPE      FORM   CARE TYPE    CARE UNIT       ID #

  No ID's found for provider and selected insurance co




          Enter ?? for more actions
     Add A Provider ID                      Delete a Provider ID
     Edit Provider Id                       Exit
Select Action: Quit// add   Add A Provider ID
CHOOSE 1-2: 2  BLUE SHIELD ID
FORM TYPE APPLIED TO: 0  BOTH UB92 AND HCFA 1500 FORMS
BILL CARE TYPE: 0  BOTH INPATIENT AND OUTPATIENT
Select IB PROVIDER ID CARE UNIT: Surgery       Ambulatory Surgery     BLUE CROSS
 OF CALIFORNIA

THE FOLLOWING WAS CHOSEN:
   INSURANCE: BLUE CROSS OF CALIFORNIA
   PROV TYPE: BLUE SHIELD ID
   FORM TYPE: BOTH UB92 & HCFA 1500 FORMS
   CARE TYPE: BOTH INPATIENT AND OUTPATIENT
   CARE UNIT: Surgery

PROVIDER ID: XXXXBS
```

*When creating a bill for a patient with this payer, if IB,Doctor7 is entered on Screen 8, this ID for the Care Unit, Surgery, will be one of the Physician/Provider's Secondary IDs available.*

```
                  **** SECONDARY PERFORMING PROVIDER IDs ****

PRIMARY INSURANCE CO: BLUE CROSS OF CALIFORNIA
PROVIDER: IB,DOCTOR7 (RENDERING)


SELECT A SECONDARY ID OR ACTION FROM THE LIST BELOW:

  1   -  NO SECONDARY ID NEEDED
  2   -  ADD AN ID FOR THIS CLAIM ONLY
  3   -  XXXXBS                          BLUE SHIELD ID   Surgery

Selection: 1//
```

### 3.5.2 Define Care Units for Billing Provider Secondary IDs

| Step | Procedure |
|---|---|
| 1 | Access the **Provider ID Maintenance** screen. |
| 2 | At the **Select Action**: prompt, press **Return** to accept the default. |
| 3 | At the **Select EDIT OPTION**: prompt, enter **4** - **Care Unit Maintenance**. |
| 4 | At the **Enter Type of Care Unit:** prompt, enter **Care Units for Billing** |

**Provider Secondary IDs**.

5 At the **Select INSURANCE CO**: prompt, enter **Blue Cross of California** for this example.

```
PROVIDER ID MAINTENANCE       May 27, 2005@11:01:51          Page:    1 of    1



               -- PROVIDER ID EDITS --
         1 > PROVIDER SPECIFIC IDS
             o PROVIDER'S OWN IDS
             o PROVIDER IDS FURNISHED BY INSURANCE CO
         2 > INSURANCE CO IDS

         4 > CARE UNIT MAINTENANCE
             o Care Units for Performing Provider IDs
             o Care Units for Billing Provider Secondary IDs
         5 > INS CO BATCH ID ENTRY


             -- NON/OTHER VA ENTITY EDITS --
         6 > NON/OTHER VA PROVIDER ID INFORMATION


          Enter ?? for more actions
     Select                    Exit
Select Action: Select//Select
Select EDIT OPTION:  (1-6): 4
Enter Type of Care Unit: Care Units for Performing Provider IDs//??
     1   Care Units for Performing Provider IDs
     2   Care Units for Billing Provider Secondary IDs
Choose 1-2: 1 Care Units for Billing Provider Secondary IDs
Select INSURANCE CO: Blue Cross of California
```

| Step | Procedure |
|---|---|
| 6 | At the **Select Action**: prompt, enter **Add**. |
| 7 | At the **Enter the Division for this Care Unit:** prompt, press **Return** to accept the default. |
| 8 | At the **Enter Care Unit Name**: prompt, enter **Anesthesia** for this example. |
| 9 | At the **Enter a Care Unit Description**: prompt, enter a free text description. |

*Users may repeat these steps to create multiple Care Units for multiple divisions.*

*Refer to **Section 3.1.2.3** to learn how to assign Billing Provider Secondary IDs to Care Units.*

```
Care Units – Billing Provider  May 27, 2005@11:17:46          Page:    1 of    0

Insurance Co: BLUE CROSS OF CALIFORNIA

Care Unit Name             Division              Description
No Care Units defined for this Insurance Co.



          Enter ?? for more actions
     Add                                    Exit
     Edit/Delete

Select Action: Quit// A   Add
Enter the Division for this Care Unit: Main Division//
Enter Care Unit name: Anesthesia
  Are you adding 'Anesthesia' as
    a new Care Unit for Main Division? No// y  (Yes)
Enter a Care Unit Description: Free Text Description

Care Unit combination filed for this Insurance Co.
PRESS ENTER TO CONTINUE…
```

The following screen will display.

```
Care Units – Billing Provider May 27, 2005@11:17:46          Page:    1 of    0

Insurance Co: BLUE CROSS/BLUE SHIELD

  Care Unit Name                    Description
------------------------------------------------------------------------------
Division: Main Division
  Anesthesia                        Free Text Description
  Reference Lab                     Free Text Description
  Home Health                       Free Text Description

Division: Remote Clinic
  Reference Lab                     Free Text Description




          Enter ?? for more actions
     Add                                    Exit
     Edit/Delete
Select Action: Quit//    QUIT
```

## 3.6. ID Parameters by Insurance Company

In addition to defining Care Units and Physician/Provider IDs in Provider ID Maintenance, there are also ID parameters that can be set for an insurance company that effect which IDs get sent on 837 claims transmissions to an insurance company.

Users need to be aware of these parameters so they can be set *if needed*. They do not need to be set unless there is a specific need for a particular insurance company.

| Step | Procedure |
|---|---|
| 1 | Access the option **Insurance Company Entry/Edit**. |
| 2 | At the **Select INSURANCE COMPANY NAME**: prompt, enter **BLUE CROSS OF CALIFORNIA** for this example. |
| 3 | From the **Insurance Company Editor,** enter the **Prov IDs/ID Param** action. |

```
Insurance Company Editor      Dec 28, 2005@11:08:48          Page:    1 of    7
Insurance Company Information for: BLUE CROSS OF CALIFORNIA
Type of Company: BLUE CROSS                     Currently Active

                           Billing Parameters
  Signature Required?: NO                          Billing Phone: 800 677-6669
           Reimburse?: WILL REIMBURSE          Verification Phone: 800 677-6669
    Mult. Bedsections: YES                     Precert Comp. Name:
     Diff. Rev. Codes:                              Precert Phone: 800 274-7767
       One Opt. Visit: NO                             *** EDI Parameters ***
  Amb. Sur. Rev. Code:                               Transmit?: YES-LIVE
  Rx Refill Rev. Code: 253                         Inst Payer ID: 47198
    Filing Time Frame: SIX MONTHS                  Prof Payer ID: 47198
     Type Of Coverage: BLUE CROSS                 Insurance Type: HMO
    Primary Form Type:                                 Bin Number:

+         Enter ?? for more actions                                          >>>
BP  Billing Parameters    IO  Inquiry Office        EA  Edit All
MM  Main Mailing Address  AC  Associate Companies   AI  (In)Activate Company
IC  Inpt Claims Office    ID  Prov IDs/ID Param     CC  Change Insurance Co.
OC  Opt Claims Office     PA  Payer                 DC  Delete Company
PC  Prescr Claims Of      RE  Remarks               VP  View Plans
AO  Appeals Office        SY  Synonyms              EX  Exit
Select Action: Next Screen// ID  Prov IDs/ID Param
```

| Step | Procedure |
|---|---|
| 4 | From the **Billing Provider IDs** screen, enter the **ID Parameters** action. |

```
Billing Provider IDs (Parent) May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co: BLUE CROSS OF CALIFORNIA    Billing Provider Secondary IDs
     ID Qualifier                ID #             Form Type
Division: Name of Main Division/Default for All Divisions
1    Electronic Plan Type        XXXXXXXXX        UB92
2    Electronic Plan Type        XXXXXXXX1X       HCFA




          Enter ?? for more actions
    Add an ID            Additional IDs              Exit
    Edit an ID           ID Parameters
    Delete an ID         VA-Lab/Facility IDs

Select Action: Edit// ID Parameters
```

| Step | Procedure |
|---|---|
| 4 | From the **Billing Provider IDs** screen, enter the **ID Parameters** action. |

The ID Parameter Maint. Screen displays the current parameter values.

5 At the **Select Action**: prompt, enter the **Edit Params** action.

```
ID Parameter Maint.          May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co.: BLUE CROSS OF CALIFORNIA

Attending/Rendering Provider Secondary ID
Default ID (HCFA): PROVIDER PLAN NETWORK
Default ID (UB92):
Require ID on Claim: HCFA 1500 REQUIRED

Referring Provider Secondary ID
Default ID (HCFA):
Require ID on Claim:

Billing Provider Secondary IDs
Use Attending/Rendering ID as Billing Provider Sec. ID?: NO
Transmit no Billing Provider Sec ID for the following Electronic Plan Types:


+          Enter ?? for more actions
    Edit Params      Edit Billing Prov Params       Exit

Select Action: Next Screen// Edit Params
```

The following screen will display.

```
Attending/Rendering Provider Secondary ID
Default ID (HCFA): PROVIDER PLAN NETWORK
Default ID (UB92):
Require ID on Claim: HCFA 1500 REQUIRED

Referring Provider Secondary ID
Default ID (HCFA): UPIN//
Require ID on Claim:

Billing Provider Secondary IDs
Send Attending/Rendering ID as Billing Provider Sec. ID?: No//

VA-Laboratory or Facility IDs
Send VA Lab/Facility IDs or Facility Data?: Yes//

Print SSN on claim
Print on HCFA?:
Print on UB92?:

Performing Provider Care Unit
Care Unit prompt: Surgery

Note: Use Provider ID Maintenance to define individual provider's IDs.
```

### 3.6.1 Define Attending/Rendering Provider Secondary ID Parameters

Users can define the type of ID that will be the default secondary ID for the Rendering Provider or Attending Physician during the creation of a claim.

A type of default secondary ID can be defined for a HCFA 1500 claim and/or a UB92 claim.

Users can also set a parameter which will make these IDs required on a claim. If they are required and the physician/provider on the claim does not have a secondary ID of the type required, the claim can not be authorized.

```
Attending/Rendering Provider Secondary ID
Default ID (HCFA): BLUE SHIELD ID
Default ID (UB92): BLUE CROSS ID
Require ID on Claim: BOTH
```

### 3.6.2 Define Referring Provider Secondary ID Parameters

Users can define the type of ID that will be the default secondary ID for the Referring Provider during the creation of a HCFA 1500 claim.

A type of default secondary ID can be defined for a HCFA 1500 claim.

Users can also set a parameter which will make this ID required on a claim. If it is required and the referring provider on the claim does not have a secondary ID of the type required, the claim can not be authorized.

The default type of ID for a Referring Provider is a UPIN but users may override this default.

```
Referring Provider Secondary ID
Default ID (HCFA): UPIN// BLUE SHIELD ID
Require ID on Claim: HCFA 1500 REQUIRED
```

### 3.6.3 Define Billing Provider Secondary ID Parameters

If an insurance company wants the Billing Provider Secondary ID (Billing Screen 3) to be the same as the Attending Physician's or the Rendering Provider's ID, users can set the Send Attending/Rendering ID as Billing Provider Sec. ID?: parameter to Yes. The default value is No.

```
Billing Provider Secondary IDs
Send Attending/Rendering ID as Billing Provider Sec. ID?: No// Yes
```

*If the payer requires the Attending/Rendering Physician/Provider's Secondary ID as the Billing Provider Secondary ID, this parameter can be set and a default Attending/Rendering ID type can be set and then users can just accept the default ID on Billing Screen 8 and it will be transmitted as the Physician/Provider's Secondary ID and the Billing Provider Secondary ID.*

### 3.6.4 Define VA Service Facility Parameters

Some insurance companies want the IDs and the facility data such as the address for the VAMC repeated in the Service Facility segments of the 837 claim transmission. There are some insurance companies that do not want IDs or facility data for the VAMC repeated. For these insurance companies, set the Send VA Lab/Facility IDs or Facility Data?: Yes// parameter to No. The default value is Yes.

```
VA-Laboratory or Facility IDs
Send VA Lab/Facility IDs or Facility Data?: Yes//
```

### 3.6.5 Define SSN Print Parameters

SSNs no longer automatically print on HCFA 1500 or UB92 forms. If an insurance company requires the physician/provider's SSN on printed claims, users can set the Print SSN on claim parameters by form type. The default value is No (blank).

```
Print SSN on claim
Print on HCFA?: Yes
Print on UB92?:
```

### 3.6.6 Define No Billing Provider Secondary IDs by Plan Type

Some insurance companies do not want any Billing Provider Secondary IDs to be transmitted in the 837 claim transmission for claims to specific plan types.

To define which plan types require no Billing Provider Secondary IDs, users must enter the plan types.

| Step | Procedure |
|---|---|
| 1 | From the **ID Parameter Maint.** screen, enter the **Edit Billing Prov Params** action. |
| | The first Billing Provider Secondary ID will still be sent with the claim regardless of this parameter. The first ID is a calculated value used by Emdeon™ for sorting purposes. |
| 2 | At the **Select Action**: prompt, enter **Add Plan**. |
| 3 | At the **Enter Electronic Plan Type**: prompt, enter **PPO** for this example. |

```
Billing Provider Parameters   May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co.: BLUE CROSS OF CALIFORNIA

Transmit No Billing Provider Sec ID for the following Electronic Plan Types:
 1 HMO



          Enter ?? for more actions
    Add Plan      Delete Plan       Exit

Select Action: Add Plan
Enter Electronic Plan Type: PPO
```

The following screen will display.

```
Billing Provider Parameters   May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co.: BLUE CROSS OF CALIFORNIA

Transmit No Billing Provider Sec ID for the following Electronic Plan Types:
 1 HMO
 2 PPO

          Enter ?? for more actions
    Add Plan      Delete Plan       Exit

Select Action: Add Plan
```

### 3.6.7 View Associated Insurance Companies, Provider IDs, and ID Parameters

When in the Insurance Company Editor, users can scroll through the information that has been defined for a particular insurance company.

Patch IB*2.0*320 added sections to display: Associated Insurance Companies; Provider IDs and ID Parameters.

```
Insurance Company Editor      Nov 22, 2005@10:26:11          Page:    5 of    7
Insurance Company Information for: BLUE CROSS OF CALIFORNIA
Type of Company: BLUE CROSS                    Currently Active
+
           Associated Insurance Companies
  This insurance company is defined as a Parent Insurance Company.
  There are 4 Child Insurance Companies associated with it.
  Select the "AC  Associate Companies" action to enter/edit the children.

                   Provider IDs
Billing Provider Secondary ID
 Main Division and Default for All Divisions/HCFA:
 Main Division and Default for All Divisions/UB92:
    Main Division Care Units:
    Anesthesia/HCFA:
    Reference Lab/HCFA:
    Reference Lab/UB92:
    Home Health/UB92:
 2nd Division Name/HCFA:
 2nd Division Name/UB92:
Additional Billing Provider Secondary IDs
 Main Division and Default for All Divisions/HCFA:
    1st ID
    2nd ID
    3rd ID
    Maximum of 6 additional IDs
 Main Division and Default for All Divisions/UB92:
    1st ID
    2nd ID
    3rd ID
    Maximum of 6 additional IDs
VA-Laboratory or Facility Secondary IDs
 Main Division and Default for All Divisions/HCFA:
    1st ID
    2nd ID
    3rd ID
    Maximum of 5 additional IDs

                   ID Parameters
```

```
Attending/Rendering Provider Secondary ID Qualifier (HCFA):
Attending/Rendering Provider Secondary ID Qualifier (UB92):
Attending/Rendering Secondary ID Requirement: NONE REQUIRED
Referring Provider Secondary ID Qualifier (HCFA):
Referring Provider Secondary ID Requirement:
Use Attending/Rendering ID as Billing Provider Sec. ID: No
Transmit no Billing Provider Sec. ID for the Electronic Plan Types:
    HMO
    PPO
Send VA Lab/Facility IDs or Facility Data: No
Require Provider's SSN To Print (HCFA): NO
Require Provider's SSN To Print (UB92): NO
```

## 3.7. Associated Insurance Companies and Copying Physician/Provider Secondary IDs and Additional Billing Provider Secondary IDs.

Patch IB*2.0*320 provides the ability for users to associate multiple Insurance Company entries with each other. If, for example, there are 45 Blue Cross/Blue Shield entries in the Insurance Company file, users can make one of these entries the Parent company and make 1 to 44 of the other entries a Child company.

Making these associations will caused the software to automatically make the Physician/Provider Secondary IDs and the Additional Billing Provider Secondary IDs the same for all associated companies.

Once these associations are made and the IDs synchronized for all the associated companies, users will be able to Add, Edit and/or Delete IDs for the associated companies from the Parent company. Changes to the IDs from a Child company will be prohibited.

If a situation changes and it becomes necessary for a Child company to have IDs that differ from those of the Parent company, users may disassociated the Child company from the Parent company.

### 3.7.1 Designate a Parent Insurance Company

| Step | Procedure |
|---|---|
| 1 | Access the **Insurance Company Editor**. |
| 2 | At the **Select INSURANCE COMPANY NAME**: prompt, enter **Blue Cross of California** for this example. |
| 3 | At the **Define Insurance Company as Parent or Child**: prompt, enter **Parent**. |

```
Insurance Company Editor      Nov 21, 2005@11:10:15          Page:    1 of    7
Insurance Company Information for: BLUE CROSS OF CALIFORNIA
Type of Company: BLUE CROSS                    Currently Active

                          Billing Parameters
  Signature Required?: NO                          Billing Phone: 800 677-6669
           Reimburse?: WILL REIMBURSE         Verification Phone: 800 677-6669
    Mult. Bedsections: YES                    Precert Comp. Name:
     Diff. Rev. Codes:                             Precert Phone: 800 274-7767
       One Opt. Visit: NO                            *** EDI Parameters ***
  Amb. Sur. Rev. Code:                               Transmit?: YES-LIVE
  Rx Refill Rev. Code: 253                         Inst Payer ID: 47198
    Filing Time Frame: SIX MONTHS                  Prof Payer ID: 47198
     Type Of Coverage: BLUE CROSS                 Insurance Type: HMO
    Primary Form Type:                                Bin Number:

+         Enter ?? for more actions                                        >>>
BP  Billing Parameters    IO  Inquiry Office         EA  Edit All
MM  Main Mailing Address  AC  Associate Companies    AI  (In)Activate Company
IC  Inpt Claims Office    ID  Prov IDs/ID Param      CC  Change Insurance Co.
OC  Opt Claims Office     PA  Payer                  DC  Delete Company
PC  Prescr Claims Of      RE  Remarks                VP  View Plans
AO  Appeals Office        SY  Synonyms               EX  Exit
Select Action: Next Screen//AC Associate Companies

Define Insurance Company as Parent or Child: P  PARENT
```

| Step | Procedure |
|---|---|
| 4 | At the Select Action: prompt, enter **Associate Companies** for this example. |
| 5 | At the **Select INSURANCE COMPANY NAME**: prompt, enter **BLUE CROSS/BLUE SHIELD 801 PINE ST. CHATTANOOGA,TN** for this example. |
| | *Steps 2 - 4 can be repeated to associate additional Insurance Companies with Blue Cross of California.* |
| | *A Parent – Child association can be removed using the Disassociate Companies action.* |
| | To stop an insurance company from being a Parent, all associations with any Child entries must be removed. After disassociating all the Child entries, users may delete the Parent using the '@' sign at the **Define Insurance Company as Parent or Child: PARENT//** prompt. |

```
Associated Insurance Co's     Nov 21, 2005@11:13:53          Page:    1 of    1
Parent Insurance Company:
     BLUE CROSS OF CALIFORNIA   PO BOX 60007              LOS ANGELES,CA

     Ins Company Name           Address                   City

     No Children Insurance Companies Found




          Enter ?? for more actions
     Associate Companies                    Exit
     Disassociate Companies
Select Action: Quit// as   Associate Companies

Select Insurance Company: BLUE CROSS/BLUE SHIELD801 PINE ST.  CHATTANOOGA,TN
```

The following screen will display.

```
Associated Insurance Co's     Nov 21, 2005@11:30:25          Page:    1 of    1
Parent Insurance Company:
     BLUE CROSS OF CALIFORNIA   PO BOX 60007              LOS ANGELES,CA

     Ins Company Name           Address                   City
  1  BLUE CROSS FEP             PO BOX 70000              VAN NUYS,CA
  2  BLUE CROSS/BLUE SHIELD     9901 LINN STA RD          LOUISVILLE,KY
  3  BLUE CROSS/BLUE SHIELD     801 PINE ST.              CHATTANOOGA,TN




          Enter ?? for more actions
     Associate Companies                    Exit
     Disassociate Companies
Select Action: Quit//
```

### 3.7.2 Designate a Child Insurance Company

An insurance company can be designated as a Child, from the Parent insurance company as demonstrated in **Section 3.7.1**.

If users want to quickly define a single insurance company as a Child, they can do this from the Insurance Company Editor.

| Step | Procedure |
|---|---|
| 1 | Access the **Insurance Company Editor**. |
| 2 | At the **Select INSURANCE COMPANY NAME**: prompt, enter **Aetna** for this example. |
| 3 | At the **Define Insurance Company as Parent or Child**: prompt, enter **Child** for this example. |

4 At the **Associate with which Parent Insurance Company**: prompt, enter the name of the insurance company that will be the Parent.
*'**??**' will provide a list of available Parent insurance companies.*

```
Insurance Company Editor      Nov 21, 2005@11:39:58          Page:    1 of    7
Insurance Company Information for: AETNA LIFE INSURANCE
Type of Company: HEALTH INSURANCE                     Currently Active

                           Billing Parameters
  Signature Required?: NO                          Billing Phone: 972 529-5085
           Reimburse?: WILL REIMBURSE         Verification Phone: 972 529-5085
    Mult. Bedsections: YES                     Precert Comp. Name:
     Diff. Rev. Codes:                              Precert Phone:
       One Opt. Visit: NO                             *** EDI Parameters ***
  Amb. Sur. Rev. Code:                                 Transmit?: YES-LIVE
  Rx Refill Rev. Code:                             Inst Payer ID: HPRNT
    Filing Time Frame: ONE YEAR                    Prof Payer ID: SPRNT
     Type Of Coverage: HEALTH INSURANCE           Insurance Type: GROUP POLICY
    Primary Form Type:                                 Bin Number:

+         Enter ?? for more actions                                          >>>
BP  Billing Parameters    IO  Inquiry Office         EA  Edit All
MM  Main Mailing Address  AC  Associate Companies    AI  (In)Activate Company
IC  Inpt Claims Office    ID  Prov IDs/ID Param      CC  Change Insurance Co.
OC  Opt Claims Office     PA  Payer                  DC  Delete Company
PC  Prescr Claims Of      RE  Remarks                VP  View Plans
AO  Appeals Office        SY  Synonyms               EX  Exit
Select Action: Next Screen// ac   Associate Companies


Define Insurance Company as Parent or Child: Child  CHILD
Associate with which Parent Insurance Company: AetNA LIFE INSURANCE       3541 W
INCHESTER RD.         ALLENTOWN     PENNSYLVANIA       Y.....................
```

### 3.7.3 Copy Physician/Provider Secondary IDs

Individual Physician/Provider Secondary IDs can be entered, edited or deleted one time from the Parent insurance company and these changes will be copied to all associated insurance companies (Child).

This can be done using the following Provider ID Maintenance options:

- Provider ID Maint→1 Provider Specific ID→Provider IDs Furnished by the Insurance Co;
- Provider ID Maint→2 Insurance Co IDs; and
- Provider ID Maint→5 Ins Co Batch ID Entry

### 3.7.4 Copy Additional Billing Provider Secondary IDs

When users are done adding, editing or deleting Additional IDs from the Parent insurance company, the changes will be copied to all associated insurance companies.

### 3.7.5 Synchronizing Associated Insurance Company IDs

There is an IRM option for synchronizing the IDs of a Parent insurance company with all of the associated Child companies. This option is intended as a backup option if the IDs

of a Parent have become out of synch with the Child companies due to a system problem.

# 4. ENTERING ELECTRONIC CLAIMS

This section briefly identifies the screens used in the billing process that contain fields critical to EDI billing. It is important that all the data transmitted in an electronic claim be accurate and appropriate. This section is just meant to highlight some specific fields that pertain to electronic processing.

## 4.1. Screen 3 – Payer Information

### 4.1.1 EDI Fields

| | |
|---|---|
| Section 1 – Transmit | When a payer has been set up to transmit claims electronically, this field will say "Yes". If the field says "No" the claim will be printed locally. |
| Section 2 – Primary, Secondary and Tertiary Payer | These fields display the Billing Provider Secondary IDs for the payers on the bill. These IDs are defined in the Insurance Company Editor. *Note: If users set the ID Parameter: Send Attending/Rendering ID as Billing Provider Sec. ID? to Yes for a payer on the claim, the Attending/Rendering ID will be sent.* |
| Section 3 – Mailing Address | This field should contain a valid mailing address for the current payer. In order to avoid EDI errors, there should be no periods or dashes such as P.O. Box, Winston-Salem, St. Paul, etc. *Exception: Medicare does not have a valid address.* |
| Section 3 – Electronic ID | This field contains the Inst Electronic Bill ID or Prof Electronic Bill ID defined in the Insurance Company Editor. Payer IDs are provided by Emdeon™ and can be found at www.envoy.com . |

```
IB,PATIENT 1   XXX-XX-XXXX   BILL#: K501XXX - Inpat/HCFA        SCREEN <3>
================================================================================
                              PAYER INFORMATION
[1] Rate Type  : REIMBURSABLE INS.           Form Type: HCFA 1500
    Responsible: INSURER                     Payer Sequence: Primary
    Bill Payer : MRA NEEDED FROM MEDICARE    Transmit: Yes

    Ins 1: MEDICARE (WNR)     WILL NOT REIMBURSE   Policy #: XXXXXXXXA
    Grp #: PART A             Whose: VETERAN       Rel to Insd: PATIENT
    Grp Nm: PART A            Insd Sex: MALE       Insured: IB,PATIENT 1

    Ins 2: BLUE CROSS OF CA                        Policy #: MES3456
    Grp #: PLAN 2             Whose: VETERAN       Rel to Insd: PATIENT
    Grp Nm: PROTECTION PLUS   Insd Sex: MALE       Insured: IB,PATIENT 1

[2] Primary Payer: 670899
    Secondary Payer: XXXXXX1X              Tertiary Payer:

[3] Mailing Address :                                  Electronic ID: XXXXID
    NO MAILING ADDRESS HAS BEEN SPECIFIED!   (Patient has Medicare)
    Send Bill to PAYER listed above.
<RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT:
```

*The 3-line mailing address displayed here is used also used by Emdeon™ to look up the Electronic ID for the payer when a claim is sent without a defined Electronic Bill ID.*

### 4.1.2 Using Care Units for Billing Provider Secondary IDs

Section 3 of Billing Screen 3 contains fields for the Billing Provider Secondary IDs for the primary, secondary and tertiary payers on a claim. Normally the default values for the site or the defined values for the division on the claim populate these fields. If any insurance company on the claim requires different Billing Provider Secondary IDs based upon Care Units, users can change the default values to the value defined for the Care Unit where the services were provided.

| Step | Procedure |
|---|---|
| 1 | At the **<RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT**: prompt, enter **2**. |
| 2 | At the **Current Bill Payer Sequence**: prompt, press **Return** to accept the default. |
| 3 | At the **Define Primary Payer ID by Care Unit?**: prompt, press **Return** to accept the default. |
| 4 | At the **Primary Payer ID**: prompt, press **Return** to accept the default. |
| 5 | At the **Define Secondary Payer ID by Care Unit?**: prompt, enter **Yes** for this example. |
| 6 | At the **Division**: prompt, press **Return** to accept the default for this example. |
| 7 | At the **Care Unit**: prompt, enter **Anesthesia** for this example. |
| 8 | At the **Secondary Payer ID**: prompt, press **Return** to accept the default. |
| | *Note: The Care Units must be defined in Provider ID Maintenance and the ID numbers must be defined in the Insurance Company Editor.* ***Refer to Section 3.2.2.3 and Section 3.5.2*** |

```
IB,PATIENT 1   XXX-XX-XXXX   BILL#: K501XXX - Inpat/HCFA        SCREEN <3>
================================================================================
                              PAYER INFORMATION
[1] Rate Type  : REIMBURSABLE INS.           Form Type: HCFA 1500
    Responsible: INSURER                     Payer Sequence: Primary
    Bill Payer : MRA NEEDED FROM MEDICARE    Transmit: Yes

    Ins 1: MEDICARE (WNR)     WILL NOT REIMBURSE   Policy #: XXXXXXXXA
    Grp #: PART A             Whose: VETERAN       Rel to Insd: PATIENT
    Grp Nm: PART A            Insd Sex: MALE       Insured: IB,PATIENT 1

    Ins 2: BLUE CROSS OF CA                        Policy #: MES3456
    Grp #: PLAN 2             Whose: VETERAN       Rel to Insd: PATIENT
    Grp Nm: PROTECTION PLUS   Insd Sex: MALE       Insured: IB,PATIENT 1

[2] Primary Payer: 670899
    Secondary Payer: XXXXXX1X              Tertiary Payer:

[3] Mailing Address :                                  Electronic ID: XXXXID
    NO MAILING ADDRESS HAS BEEN SPECIFIED!   (Patient has Medicare)
    Send Bill to PAYER listed above.
<RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT: 2
Current Bill Payer Sequence: PRIMARY INSURANCE//
Define Primary Payer ID by Care Unit? No//
Primary Payer ID: 670899//
Define Secondary Payer ID by Care Unit? No//Yes
Division: Main Division//
Care Unit: ??
       1 Anesthesia
       2 Reference Lab
       3 Home Health
Care Unit: 1 Anesthesia
Secondary Payer ID: XXXXXXX//
```

## 4.2. Screen 8 – Physician/Provider and Print Information

### 4.2.1 EDI Fields UB92/HCFA 1500

| | |
|---|---|
| Section 2/3 – Providers | When a Physician/Provider is entered here, the system finds the appropriate IDs for him/her. The Primary IDs are the providers' SSNs and their secondary IDs are those IDs that users have defined as the provider's own or as those provided by an insurance company. |
| Section 8 – Other Facility<br>Section 4 – Other Facility, CLIA#, Mammography Certification Number | These are the sections through which the names of outside facilities are entered. The primary and secondary Laboratory or Facility IDs are then transmitted with the claim.<br>The CLIA# and Mammography Certification Number can also be sent with a professional laboratory claim or mammography claim. |
| Section 6 – Force to Print | Users can set this field to force a claim to print either locally or at the clearinghouse. |
| Section 7 – Provider ID Maint | This is a link to the Provider ID Maintenance function. |

```
IB,PATIENT2   000-00-0000   BILL#: K300XX - Outpat/UB92  SCREEN<8>
================================================================================
                          BILLING - SPECIFIC INFORMATION
[1] Bill Remark       : UNSPECIFIED [NOT REQUIRED]
    ICN/DCN(s)        : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code(s)  : UNSPECIFIED [NOT REQUIRED]
    Admitting Dx      : UNSPECIFIED [NOT REQUIRED]
    Admission Source  : UNSPECIFIED
[2] Providers         :
     - ATTENDING (MD) : IB,DOCTOR 2
[3] Form Locator 2    : UNSPECIFIED [NOT REQUIRED]
    Form Locator 11   : UNSPECIFIED [NOT REQUIRED]
[4] Form Locator 31   : UNSPECIFIED [NOT REQUIRED]
[5] Form Locator 56   : UNSPECIFIED [NOT REQUIRED]
    Form Locator 78   : UNSPECIFIED [NOT REQUIRED]
[6] Force To Print?   : NO FORCED PRINT
[7] Provider ID Maint  : (Edit Provider ID information)
[8] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]


<RET> to CONTINUE, 1-6 to EDIT, '^N' for screen N, or '^' to QUIT:
```

```
IB,PATIENT 3   000-00-0000   BILL#: K600XX - Outpat/HCFA        SCREEN <8>
================================================================================
                          BILLING - SPECIFIC INFORMATION
[1] Unable To Work From: UNSPECIFIED [NOT REQUIRED]
    Unable To Work To  : UNSPECIFIED [NOT REQUIRED]
[2] Admitting Dx       : UNSPECIFIED [NOT REQUIRED]
    ICN/DCN(s)         : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code(s)   : UNSPECIFIED [NOT REQUIRED]
[3] Providers          :
     - RENDERING (MD)  : IB,DOCTOR 1
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
    Lab CLIA #         : UNSPECIFIED
    Mammography Cert # : UNSPECIFIED
[5] Form Locator 19    : UNSPECIFIED [NOT REQUIRED]
[6] Print Main Facility Box 32: UNSPECIFIED [NOT REQUIRED]
    Force To Print?    : NO FORCED PRINT
[7] Provider ID Maint  : (Edit Provider ID information)Billing Process Overview
```

## 4.3. UB-92 Claims

The following screens provide a simplified example of a UB-92 claim:

| Step | Procedure |
|---|---|
| 1 | When processing a UB-92 claim, information on Screens 1 and 2 should be reviewed for correctness. Press the **Return** key to move from one screen to the next. |
| 2 | On Screen 3, the payer information is reviewed for correctness. The patient may have more than one insurance policy. If the correct information is not displayed, select a section (1, 2, or 3 ) and edit the necessary fields. Press **Return** to continue to Screen 5. |

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Outpat/UB92 SCREEN <3>
```

```
================================================================================
                              PAYER INFORMATION
[1] Rate Type  : REIMBURSABLE INS.          Form Type: UB-92
    Responsible: INSURER                    Payer Sequence: Primary
    Bill Payer : Blue Cross Fep              Transmit: Yes

    Ins 1: Blue Cross Fep                        Policy #: RXXXXXXXXX
    Grp #: 100               Whose: VETERAN      Rel to Insd: PATIENT
    Grp Nm: STANDARD FAMILY  Insd Sex: MALE      Insured: IB,PATIENT3

[2] Primary  : 010100
    Secondary:                              Tertiary :

[3] Mailing Address :                                 Electronic ID: 12B54
    Blue Cross Fep
    P O Box 10401
    Birmingham, AL  352020401


<RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT:
```

| Step | Procedure |
|---|---|
| 3 | On Screen 5, enter sections **1-7** to type in the diagnosis information, the services/procedures provided and the date of service. Include the Occurrence and Condition Code when required. Press the **Return** key to move to Screen 7. |

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Outpat/UB92  SCREEN <5>
================================================================================
                        EVENT - OUTPATIENT INFORMATION
[1] Event Date : XXX XX, XXXX
[2] Prin. Diag.: ABDOM PAIN, L L QUADR - 789.04
    Other Diag.: BENIGN NEOPLASM LG BOWEL - 211.3
    Other Diag.: DIVERTICULOSIS OF COLON - 562.10
[3] OP Visits  : XXX XX, XXXX
[4] Cod. Method: HCPCS
    CPT Code   : LESION REMOVE COLONOSCOPY 45384              XXX XX, XXXX
[5] Rx. Refills: UNSPECIFIED [NOT REQUIRED]
[6] Pros. Items: UNSPECIFIED [NOT REQUIRED]
[7] Occ. Code  : ONSET OF SYMPTOMS/ILLNESS            XXX XX, XXXX
[8] Cond. Code : UNSPECIFIED [NOT REQUIRED]
[9] Value Code : UNSPECIFIED [NOT REQUIRED]


<RET> to CONTINUE, 1-9 to EDIT, '^N' for screen N, or '^' to QUIT:
```

| Step | Procedure |
|---|---|
| 4 | If all information has been entered correctly, this screen will be auto-populated (as shown below) with the necessary information to send the claim electronically. *Make sure that the Disch Stat field in Section 1 is populated*. Press the **Return** key to move to Screen 8. |

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Outpat/UB92  SCREEN <7>
================================================================================
                          BILLING - GENERAL INFORMATION
[1] Bill Type    : 131               Loc. of Care: HOSPITAL - INPT OR OPT (INCLU
    Covered Days: UNSPECIFIED       Bill Classif: OUTPATIENT
    Non-Cov Days: UNSPECIFIED          Timeframe: ADMIT THRU DISCHARGE
    Charge Type : INSTITUTIONAL       Disch Stat: DISCHARGED TO HOME OR SELF CAR
    Form Type   : UB-92                 Division: MONTGOMERY VAMC
[2] Sensitive?  : UNSPECIFIED                 Assignment: YES
[3] Bill From   : XXX XX, XXXX                   Bill To: XXX XX, XXXX
[4] OP Visits   : XXX XX, XXXX
[5] Rev. Code   : 750-GASTR-INST SVS     45384      $2,137.44  OUTPATIENT VISIT
    OFFSET      :       $0.00   [NO OFFSET RECORDED]
    BILL TOTAL  :   $2,137.44
[6] Rate Sched  : (re-calculate charges)
[7] Prior Claims: UNSPECIFIED

<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT:
```

| Step | Procedure |
|---|---|
| 5 | On Screen 8, enter **2** to enter the name of the Attending Physician. A UB92 claim can also contain an Operating or Other Physician. |

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Outpat/UB92  SCREEN<8>
================================================================================
                           BILLING - SPECIFIC INFORMATION
[1] Bill Remark       : UNSPECIFIED [NOT REQUIRED]
    ICN/DCN(s)        : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code(s)  : UNSPECIFIED [NOT REQUIRED]
    Admitting Dx      : UNSPECIFIED [NOT REQUIRED]
    Admission Source  : UNSPECIFIED
[2] Providers         :
     - ATTENDING      : UNSPECIFIED
[3] Form Locator 2    : UNSPECIFIED [NOT REQUIRED]
    Form Locator 11   : UNSPECIFIED [NOT REQUIRED]
[4] Form Locator 31   : UNSPECIFIED [NOT REQUIRED]
[5] Form Locator 56   : UNSPECIFIED [NOT REQUIRED]
    Form Locator 78   : UNSPECIFIED [NOT REQUIRED]
[6] Force To Print?   : NO FORCED PRINT
[7] Provider ID Maint  : (Edit Provider ID information)
[8] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]


<RET> to CONTINUE, 1-6 to EDIT, '^N' for screen N, or '^' to QUIT:
```

*The Primary ID (SSN) for the Attending, Operating or Other Physician is always transmitted with a claim.*

*The Secondary IDs for the Attending, Operating or Other Physician are determined from entries in Provider ID Maintenance.*

*If users have set a default ID type and made it required for the current payer, the claim can not be authorized if the physician does not have an ID of that type defined.*

When a provider is first added to Screen 8, the user will be shown a screen that contains a list of all the provider's IDs, the ID type and, optionally, the care unit on file

for the provider's IDs. This will include the provider's own IDs, the provider's IDs assigned by the insurance company, the insurance company defaults, if any, and all IDs assigned to the provider by care unit.

The first 2 entries in this list will always be:
1 - NO SECONDARY ID NEEDED
2 - ADD AN ID FOR THIS CLAIM ONLY

*Any ID entered on screen 8 will automatically override any default provider secondary ID that exists for the same ID Qualifier for this claim ONLY.*

```
**** SECONDARY PERFORMING PROVIDER IDs ****

PRIMARY INSURANCE CO: BLUE CROSS CA (WY)
PROVIDER: IB,PHYSICIAN4 (ATTENDING)

INS. COMPANY'S DEFAULT SECONDARY ID TYPE IS: BLUE CROSS ID

SELECT A SECONDARY ID OR ACTION FROM THE LIST BELOW:

  1    -  NO SECONDARY ID NEEDED
  2    -  ADD AN ID FOR THIS CLAIM ONLY
  3    -  <INS DEF> XXXXBCROSS              BLUE CROSS ID
  4    -  WYXXXX                            ST LIC (WY)

Selection: 3//
```

If there is a default secondary ID found, based on the insurance company parameters and the Provider ID is defined in the Provider ID Maintenance, this will be the 3rd entry in the list and will be preceded with the text <**INS DEF**>. If this ID exists, the default for the Selection prompt will be **3.**

If no default ID exists, the default for the selection prompt will be **1** – No Secondary ID needed.

Any care units assigned to an ID using Provider ID Maintenance are displayed at the far right of the ID line. You no longer have to enter a care unit on the bill.

You can make a selection from the list by choosing the number preceding the ID you want to assign to the provider for the bill. This will add both the ID Qualifier and the ID number to the claim.

*Note: If the Provider has multiple IDs defined, the one you select or the new one time only ID that you enter, will appear on Screen 8 and will be the first ID sent but the system will still transmit the remaining IDs. The one you select will just be the first one transmitted. The maximum number that will be transmitted is five.*

If none of the IDs are valid for the provider for the claim, you can add a new ID *for this claim only*.

| Step | Procedure |
|---|---|
| 6 | At the **Selection** prompt, type **2** to add an ID for this claim only. |
| 7 | At the **PRIM INS PERF PROV SECONDARY ID TYPE**: prompt, enter the ID Qualifier that the primary payer requires as a secondary ID type. Type two question marks (**??**) to see the list of possible choices. (For this example, type **Location Number** as the secondary ID Qualifier). |
| 8 | At the **PRIM INS PERF PROV SECONDARY ID**: prompt, enter the **ID** number provided by the payer. In this example, type **XXXXA**. |

```
Selection: 3// 2
  PRIM INS PERF PROV SECONDARY ID TYPE: ??
   Choose from:
   BLUE CROSS ID
   BLUE SHIELD ID
   COMMERCIAL ID
   LOCATION NUMBER
   MEDICARE PART A
   MEDICARE PART B

  PRIM INS PERF PROV SECONDARY ID TYPE: LOCATION NUMBER
  PRIM INS PERF PROV SECONDARY ID: XXXXA
```

After an ID and ID Qualifier are added to the claim for a provider, the provider's name and the selected ID are displayed on Screen 8. These fields can be edited/deleted.

If a physician/provider is deleted, the next time the provider entry is accessed, the list of valid IDs will be displayed again.

Unless both the **ID Qualifier** and the **ID #** are defined, no override of the default ID will occur when the claim is transmitted.

| Valid Secondary ID Types for Current Payer | |
|---|---|
| Attending/Operating/Other (UB92) | State License; Blue Cross; Blue Shield; Medicare Part A; UPIN; TRICARE; Commercial ID; Location Number; Network ID; SSN; State Industrial and Accident Provider |
| Rendering/Referring/Supervising (HCFA) | State License; Blue Shield; Medicare Part B; UPIN; TRICARE; Commercial ID; Location Number; Network ID; SSN; State Industrial and Accident Provider |

| Valid Secondary ID Types for Other Payer (Not Current) | |
|---|---|
| Attending/Operating/Other (UB92) | Blue Cross; Blue Shield; Medicare; Commercial ID; Location Number |
| Rendering (HCFA) | Blue Shield; Medicare Part A and Part B; Commercial ID; Location Number; Network ID |

| | |
|---|---|
| Referring (HCFA) | Blue Shield; Medicare Part A and Part B; Commercial ID; Location Number; Network ID |
| Supervising (HCFA) | Blue Shield; Medicare Part A and Part B; Commercial ID; Network ID |

| Step | Procedure |
|---|---|
| 9 | At the **<RET> to Continue**: prompt (any screen), enter **?ID** to see what IDs will be transmitted with the claim. |

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Outpat/UB92  SCREEN<8>
================================================================================
                         BILLING - SPECIFIC INFORMATION
[1] Unable To Work From: UNSPECIFIED [NOT REQUIRED]
    Unable To Work To  : UNSPECIFIED [NOT REQUIRED]
[2] Admitting Dx       : UNSPECIFIED [NOT REQUIRED]
    ICN/DCN(s)         : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code(s)   : UNSPECIFIED [NOT REQUIRED]
[3] Providers          :
     - ATTENDING (MD)  : IB,PHYSICIAN4 [P]XXXXA
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
    Lab CLIA #         : UNSPECIFIED
    Mammography Cert # : UNSPECIFIED
[5] Form Locator 19    : UNSPECIFIED [NOT REQUIRED]
[6] Print Main Facility Box 32: UNSPECIFIED [NOT REQUIRED]
    Force To Print?    : NO FORCED PRINT
[7] Provider ID Maint  : (Edit Provider ID information)



<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT: ?ID


IF THIS BILL IS TRANSMITTED ELECTRONICALLY, THE FOLLOWING IDS WILL BE SENT:
  PRIMARY INS CO: BLUE CROSS CA (WY) <<<Current Ins
SECONDARY INS CO: TPM TRUST

PROVIDER IDs: (VISTA RECORDS OP1,OP2,OP4,OP8,OP9,OPR2,OPR3,OPR4,OPR5,OPR8):
     ATTENDING/RENDERING: IB,PHYSICIAN4
        SSN:                        000000000
        SECONDARY IDs
        (P) LOCATION NUMBER         XXXXA
        (P) BLUE CROSS ID           XXXXBCROSS
        (P) ST LIC (WY)             WYXXXX
```

| Step | Procedure |
|---|---|
| 10 | Press the **Return** key to move through the fields. At the **Want To Authorize Bill At This Time?:** and **Authorize Bill Generation?:** prompts, enter **Yes**. The claim is now complete and will be transmitted to the FSC in Austin at the next regularly scheduled transmission time. |

```
WANT TO EDIT SCREENS? NO// <ENTER>
WANT TO AUTHORIZE BILL AT THIS TIME? No// YES
AUTHORIZE BILL GENERATION?: YES
Adding  bill to BILL TRANSMISSION File.

  Bill will be submitted electronically
Passing completed Bill to Accounts Receivable.  Bill is no longer editable.
Completed Bill Successfully sent to Accounts Receivable.

This Bill Can Not Be Printed Until Transmit Confirmed


This Outpatient INSTITUTIONAL bill may have corresponding PROFESSIONAL
charges.
```

## 4.4. HCFA 1500 Claims

The following screens provide a simplified example of a HFCA 1500 claim.

| Step | Procedure |
|---|---|
| 1 | When processing a HCFA 1500 claim, information on Screens 1 and 2 should be reviewed for correctness. Press the **Return** key to move from one screen to the next. |
| 2 | On Screen 3, the payer information is reviewed for correctness. The patient may have more than one insurance policy. If the correct information is not displayed, select a section (1, 2, or 3 ) and edit the necessary fields. Press **Return** to continue to Screen 4. |

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Inpat/HCFA SCREEN <3>
================================================================================
                              PAYER INFORMATION
[1] Rate Type  : REIMBURSABLE INS.          Form Type: UB-92
    Responsible: INSURER                    Payer Sequence: Primary
    Bill Payer : Blue Cross Fep              Transmit: Yes

    Ins 1: Blue Cross Fep                          Policy #: R00000000
    Grp #: 100                Whose: VETERAN       Rel to Insd: PATIENT
    Grp Nm: STANDARD FAMILY   Insd Sex: MALE       Insured: IB,PATIENT3

[2] Primary  : 010100
    Secondary:                              Tertiary :

[3] Mailing Address :                                  Electronic ID: 12B54
    Blue Cross Fep
    P O Box 10401
    Birmingham, AL  352020401

<RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT:
```

| Step | Procedure |
|---|---|
| 3 | Specify the correct diagnosis and procedure code(s) that must be on this claim. Press the **Return** key to move to Screen 6. |

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Inpat/HCFA SCREEN <4>
================================================================================
    EVENT - INPATIENT INFORMATION
[1] Admission : XXX XX, XXXX, 10:56:29 pm          Accident Hour: UNSPECIFIED
    Source : CLINIC REFERRAL                          Type: URGENT
[2] Discharge.: XXX XX, XXXX @14:59
    Status:  DISCHARGED TO HOME OR SELF CARE
[3] Prin. Diag.: URIN TRACT INFECTION NOS – 559.0
    Other Diag.: PROTEIN INFECTION NOS – 041.6
    Other Diag.: HYPERTROPHY BENIGN PROSTATE – 600.0
[4] Cod. Method: HCPCS
    CPT Code   : US EXAM, ABDOM, COMPLETE 76700-26        600.0    XXX XX, XXXX
[5] Pros. Items: UNSPECIFIED [NOT REQUIRED]
[6] Occ. Code  : ONSET OF SYMPTOMS/ILLNESS          XXX XX, XXXX
[7] Cond. Code : MEDICAL APPROPRIATENESS
[8] Value Code : UNSPECIFIED [NOT REQUIRED]
```

| Step | Procedure |
|---|---|
| 4 | Verify that the Form Type is HCFA 1500 and that the date of billing is entered. Make sure the Disch Stat field is populated. If all the data have been entered correctly, section 4 should display the correct revenue codes and costs. Press the **Return** to move to Screen 8. |

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Inpat/HCFA SCREEN <6>
================================================================================
                        BILLING - GENERAL INFORMATION
[1] Bill Type   : 131              Loc. of Care: HOSPITAL - INPT OR OPT(INCLU
    Covered Days: UNSPECIFIED      Bill Classif: OUTPATIENT
    Non-Cov Days: UNSPECIFIED         Timeframe: ADMIT THRU DISCHARGE
    Charge Type : INSTITUTIONAL      Disch Stat:
    Form Type   : HCFA 1500               Division: MONTGOMERY VAMC
[2] Sensitive?  : UNSPECIFIED                Assignment: YES
[3] Bill From   : XXX XX, XXXX                  Bill To: XXX XX, XXXX
[4] Bedsection : GENERAL MEDICAL SERVICE
    LOS    : 1
[5] Rev. Code   : 500-OUTPATIENT SVCS     99221      $137.44  GENERAL MEDICAL
    OFFSET      :       $0.00   [NO OFFSET RECORDED]
    BILL TOTAL  :   $137.44
[6] Rate Sched  : (re-calculate charges)
[7] Prior Claims: UNSPECIFIED



<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT:
```

| Step | Procedure |
|---|---|
| 5 | From Screen 8, select section **2** to enter the name of the **Rendering Provider**. Enter a **Referring Provider** if required by the payer for the procedure codes on the claim. |

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Inpat/HCFA SCREEN <8>
==========================================================================
                         BILLING - SPECIFIC INFORMATION
[1] Unable To Work From: UNSPECIFIED [NOT REQUIRED]
    Unable To Work To  : UNSPECIFIED [NOT REQUIRED]
[2] Admitting Dx       : 600.0 - HYPERTROPHY BENIGN PROSTATE
    ICN/DCN(s)         : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code(s)   : UNSPECIFIED [NOT REQUIRED]
[3] Providers          :
     - RENDERING (MD)  : IB,PHYSICIAN4 [P]XXXXBCROSS
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
    Lab CLIA #         : UNSPECIFIED
    Mammography Cert # : UNSPECIFIED
[5] Form Locator 19    : UNSPECIFIED [NOT REQUIRED]
[6] Print Main Facility Box 32: UNSPECIFIED [NOT REQUIRED]
    Force To Print?    : NO FORCED PRINT
[7] Provider ID Maint  : (Edit Provider ID information)


<RET> to CONTINUE, 1-6 to EDIT, '^N' for screen N, or '^' to QUIT:
```

*The Primary ID (SSN) for the Attending, Operating or Other Physician is always transmitted with a claim.*

*The Secondary IDs for the Attending, Operating or Other Physician are determined from entries in Provider ID Maintenance.*

*If users have set a default ID type and made it required for the current payer, the claim can not be authorized if the physician does not have an ID of that type defined.*

When a provider is first added to screen 8, the user will be shown a screen that contains a list of all the provider's IDs, the ID type and, optionally, the care unit on file for the provider's IDs. This will include the provider's own IDs, the provider's IDs assigned by the insurance company, the insurance company defaults, if any, and all IDs assigned to the provider by care unit.

The first 2 entries in this list will always be:
1 - NO SECONDARY ID NEEDED
2 - ADD AN ID FOR THIS CLAIM ONLY

*Any ID entered on screen 8 will automatically override any default provider secondary ID that exists for the same ID Qualifier for this claim ONLY.*

```
**** SECONDARY PERFORMING PROVIDER IDs ****

PRIMARY INSURANCE CO: BLUE CROSS CA (WY)
PROVIDER: IB,PHYSICIAN4 (ATTENDING)

INS. COMPANY'S DEFAULT SECONDARY ID TYPE IS: BLUE SHIELD ID

SELECT A SECONDARY ID OR ACTION FROM THE LIST BELOW:

  1    -  NO SECONDARY ID NEEDED
  2    -  ADD AN ID FOR THIS CLAIM ONLY
  3    -  <INS DEF> XXXXBSHIELD            BLUE SHIELD ID
  4    -  WYXXXX                          ST LIC (WY)

Selection: 3//
```

If there is a default secondary ID found, based on the insurance company parameters and the Provider ID is defined in the Provider ID Maintenance, this will be the 3rd entry in the list and will be preceded with the text <**INS DEF**>. If this ID exists, the default for the Selection prompt will be **3.**

If no default ID exists, the default for the selection prompt will be **1** – No Secondary ID needed.

Any care units assigned to an ID using Provider ID Maintenance are displayed at the far right of the ID line. You no longer have to enter a care unit on the bill.

You can make a selection from the list by choosing the number preceding the ID you want to assign to the provider for the bill. This will add both the ID Qualifier and the ID number to the claim.

*Note: If the Provider has multiple IDs defined, the one you select or the new one time only ID that you enter, will appear on Screen 8 and will be the first ID sent but the system will still transmit the remaining IDs. The one you select will just be the first one transmitted. The maximum number that will be transmitted is five.*

If none of the IDs are valid for the provider for the claim, you can add a new ID *for this claim only*.

| Step | Procedure |
|---|---|
| 6 | At the **Selection** prompt, type **2** to add an ID for this claim only. |
| 7 | At the **PRIM INS PERF PROV SECONDARY ID TYPE**: prompt, enter the ID Qualifier that the primary payer requires as a secondary ID type. Type two question marks (**??**) to see the list of possible choices. (For this example, type **Location Number** as the secondary ID Qualifier). |
| 8 | At the **PRIM INS PERF PROV SECONDARY ID**: prompt, enter the **ID** number provided by the payer. In this example, type **XXXXA**. |

```
Selection: 3// 2
  PRIM INS PERF PROV SECONDARY ID TYPE: ??
   Choose from:
   BLUE CROSS ID
   BLUE SHIELD ID
   COMMERCIAL ID
   LOCATION NUMBER
   MEDICARE PART A
   MEDICARE PART B

  PRIM INS PERF PROV SECONDARY ID TYPE: LOCATION NUMBER
  PRIM INS PERF PROV SECONDARY ID: XXXXA
```

After an ID and ID Qualifier are added to the claim for a provider, the provider's name and the selected ID are displayed on Screen 8. These fields can be edited/deleted.

If a physician/provider is deleted, the next time the provider entry is accessed, the list of valid IDs will be displayed again.

*Unless **both** the **ID Qualifier** and the **ID #** are defined, no override of the default ID will occur when the claim is transmitted.*

| Valid Secondary ID Types for Current Payer | |
|---|---|
| Attending/Operating/Other (UB92) | State License; Blue Cross; Blue Shield; Medicare Part A; UPIN; TRICARE; Commercial ID; Location Number; Network ID; SSN; State Industrial and Accident Provider |
| Rendering/Referring/Supervising (HCFA) | State License; Blue Shield; Medicare Part B; UPIN; TRICARE; Commercial ID; Location Number; Network ID; SSN; State Industrial and Accident Provider |

| Valid Secondary ID Types for Other Payer (Not Current) | |
|---|---|
| Attending/Operating/Other (UB92) | Blue Cross; Blue Shield; Medicare Part A and Part B; UPIN; TRICARE; Commercial ID; Location Number |
| Rendering (HCFA) | Blue Shield; Medicare Part A and Part B; Commercial ID; Location Number; Network ID |
| Referring (HCFA) | Blue Shield; Medicare Part A and Part B; Commercial ID; Location Number; Network ID |
| Supervising (HCFA) | Blue Shield; Medicare Part A and Part B; Commercial ID; Network ID |

| Step | Procedure |
|---|---|
| 9 | At the **<RET> to Continue**: prompt (any screen), enter **?ID** to see what IDs will be transmitted with the claim. |

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Inpat/HCFA  SCREEN<8>
================================================================================
                         BILLING - SPECIFIC INFORMATION
[1] Unable To Work From: UNSPECIFIED [NOT REQUIRED]
    Unable To Work To  : UNSPECIFIED [NOT REQUIRED]
[2] Admitting Dx       : UNSPECIFIED [NOT REQUIRED]
    ICN/DCN(s)         : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code(s)   : UNSPECIFIED [NOT REQUIRED]
[3] Providers          :
     - RENDERING (MD)  : IB,PHYSICIAN4
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
    Lab CLIA #         : UNSPECIFIED
    Mammography Cert # : UNSPECIFIED
[5] Form Locator 19    : UNSPECIFIED [NOT REQUIRED]
[6] Print Main Facility Box 32: UNSPECIFIED [NOT REQUIRED]
    Force To Print?    : NO FORCED PRINT
[7] Provider ID Maint  : (Edit Provider ID information)



<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT: ?ID


IF THIS BILL IS TRANSMITTED ELECTRONICALLY, THE FOLLOWING IDS WILL BE SENT:
  PRIMARY INS CO: BLUE CROSS CA (WY) <<<Current Ins
SECONDARY INS CO: TPM TRUST

PROVIDER IDs: (VISTA RECORDS OP1,OP2,OP4,OP8,OP9,OPR2,OPR3,OPR4,OPR5,OPR8):
     ATTENDING/RENDERING: IB,PHYSICIAN4
        SSN:                        000000000
        SECONDARY IDs
        (P) LOCATION NUMBER         XXXXA
        (P) BLUE SHIELD ID          XXXXBSHIELD
        (P) ST LIC (WY)             WYXXXX
```

| Step | Procedure |
|---|---|
| 10 | Press the **Return** key to move through the fields. At the **Want To Authorize Bill At This Time?:** and **Authorize Bill Generation?:** prompts, enter **Yes**. The claim is now complete and will be transmitted to the FSC in Austin at the next regularly scheduled transmission time. |

```
Executing A/R edits
No A/R errors found

WANT TO EDIT SCREENS? NO//

THIS BILL WILL BE TRANSMITTED ELECTRONICALLY

WANT TO AUTHORIZE BILL AT THIS TIME? No// YES
AUTHORIZE BILL GENERATION?: YES
  Adding  bill to BILL TRANSMISSION File.

  Bill will be submitted electronically
Passing completed Bill to Accounts Receivable.  Bill is no longer editable.
Completed Bill Successfully sent to Accounts Receivable.

This Bill Can Not Be Printed Until Transmit Confirmed
```

## 4.5. Lab Claims

EDI Enhanced HIPAA format allows users to enter a CLIA# when billing for certain laboratory procedures. The VA's CLIA # must be entered on Screen 8 when billing a Medicare secondary payer for laboratory and pathology procedures that are not reimbursed in full by Medicare. A list of these CPT codes may be found on the MRA Training page of VistA University: http://vaww.vistau.med.va.gov/VistaU/e-bp/e-mra.htm

The following screens provide a simplified example of a lab claim:

| Step | Procedure |
|---|---|
| 1 | When processing a Laboratory claim, information on Screens 1 and 2 should be reviewed for correctness. Press the **Return** key to move from one screen to the next. |
| 2 | On Screen 3, the payer information is reviewed for correctness. The patient may have more than one insurance policy. If the correct information is not displayed, select a section (1, 2, or 3 ) and edit the necessary fields. Press **Return** to continue to Screen 5. |

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Outpat/HCFA SCREEN <3>
================================================================================
                                PAYER INFORMATION
[1] Rate Type  : REIMBURSABLE INS.          Form Type: HCFA
    Responsible: INSURER                    Payer Sequence: Primary
    Bill Payer : Blue Cross Fep              Transmit: Yes

    Ins 1: Blue Cross Fep                        Policy #: R00000000
    Grp #: 100               Whose: VETERAN      Rel to Insd: PATIENT
    Grp Nm: STANDARD FAMILY  Insd Sex: MALE      Insured: IB,PATIENT3
DON

[2] Primary  : 010100
    Secondary:                              Tertiary :

[3] Mailing Address :                                  Electronic ID: 12B54
    Blue Cross Fep
    P O Box 10401
    Birmingham, AL  352020401


<RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT:
```

| Step | Procedure |
|---|---|
| 3 | Specify the correct diagnosis and procedure code(s) that must be on this claim. Press the **Return** key to move to Screen 7. |

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Outpat/HCFA  SCREEN <5>
================================================================================
                         EVENT - OUTPATIENT INFORMATION
[1] Event Date : XXX XX,XXXX
[2] Prin. Diag.: URINARY FREQUENCY - 788.41
[3] OP Visits  : XXX XX,XXXX
[4] Cod. Method: HCPCS
    CPT Code   : URINALYSIS, AUTO W/SCOPE 81001        XXX XX,XXXX
    CPT Code   : URINE BACTERIA CULTURE 87088          XXX XX,XXXX
[5] Rx. Refills: UNSPECIFIED [NOT REQUIRED]
[6] Pros. Items: UNSPECIFIED [NOT REQUIRED]
[7] Occ. Code  : UNSPECIFIED [NOT REQUIRED]
[8] Cond. Code : UNSPECIFIED [NOT REQUIRED]
[9] Value Code : UNSPECIFIED [NOT REQUIRED]

<RET> to CONTINUE, 1-9 to EDIT, '^N' for screen N, or '^' to QUIT:
```

| Step | Procedure |
|---|---|
| 4 | Verify that the Form Type is HCFA 1500 and that the date of billing is entered. Make sure the Disch Stat field is populated. If all the data have been entered correctly, section 4 should display the correct revenue codes and costs. Press the **Return** to move to Screen 8. |

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Outpat/HCFA  SCREEN <7>
================================================================================
                          BILLING - GENERAL INFORMATION
[1] Bill Type   : 131              Loc. of Care: HOSPITAL - INPT OR OPT (INCLU
    Covered Days: UNSPECIFIED      Bill Classif: OUTPATIENT
    Non-Cov Days: UNSPECIFIED         Timeframe: ADMIT THRU DISCHARGE
    Charge Type : INSTITUTIONAL      Disch Stat:
    Form Type   : HCFA 1500            Division: MONTGOMERY VAMC
[2] Sensitive?  : UNSPECIFIED                 Assignment: YES
[3] Bill From   : XXX XX,XXXX                   Bill To: XXX XX,XXXX
[4] OP Visits   : XXX XX,XXXX
[5] Rev. Code   : 306-LAB/BACT-MICRO     87088      $33.20  OUTPATIENT VISIT
    Rev. Code   : 307-GASTR-INST SVS     81001      $12.77  OUTPATIENT VISIT
    OFFSET      :       $0.00   [NO OFFSET RECORDED]
    BILL TOTAL  :   $45.97
[6] Rate Sched  : (re-calculate charges)
[7] Prior Claims: UNSPECIFIED


<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT:
```

| Step | Procedure |
|---|---|
| 5 | From Screen 8, enter 3 to add a **Rendering** and **Referring** provider. |
| 6 | To edit, select Section 4 and enter the **CLIA** # if required by the payer. |
| | *After Patch IB*2.0*320, the billing software will automatically populate the CLIA# for the division on the claim when the claim is for the Service Type = 5 (Diagnostic Laboratory) if the CLIA# exists in the VistA Institution file. Users may override this value for the current claim only.* |
| | *For outside laboratory services, the billing software will automatically populate the CLIA# if there is a Laboratory or Facility secondary ID defined for the outside facility with a ID Qualifier of X4 (CLIA #).* |
| | *There will be a Error Message for laboratory claims to Medicare when there is no CLIA# on the claim and a Warning Message for laboratory claims to other payers when there is no CLIA# on the claim.* |

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Outpat/HCFA  SCREEN<8>
================================================================================
                         BILLING - SPECIFIC INFORMATION
[1] Unable To Work From: UNSPECIFIED [NOT REQUIRED]
    Unable To Work To  : UNSPECIFIED [NOT REQUIRED]
[2] Admitting Dx       : UNSPECIFIED [NOT REQUIRED]
    ICN/DCN(s)         : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code(s)   : UNSPECIFIED [NOT REQUIRED]
[3] Providers          :
     - REFERRING (MD)  : IB,PHYSICIAN5  [P]XX0000
     - RENDERING (MD)  : IB,PHYSICIAN4  [P]XXX123
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
    Lab CLIA #         : DXXXX000
    Mammography Cert # :
[5] Form Locator 19    : UNSPECIFIED [NOT REQUIRED]
[6] Print Main Facility Box 32: UNSPECIFIED [NOT REQUIRED]
    Force To Print?    : NO FORCED PRINT
[7] Provider ID Maint  : (Edit Provider ID information)

<RET> to CONTINUE, 1-6 to EDIT, '^N' for screen N, or '^' to QUIT:
```

*Note: There is a new field in Section 4 for the Mammography Certification Number where users can enter a certification number on claims for mammography exams. The known Mammography Certification Numbers will be stored in the Institution file, one per site.*

### 4.6. Pharmacy Claims

HCFA pharmacy claims can be submitted electronically to Emdeon™ where they will be printed and mailed.

The following screens give a simplified example of a pharmacy claim.

| Step | Procedure |
|---|---|
| 1 | When processing a Pharmacy claim, information on Screens 1 and 2 should be reviewed for correctness. Press the **Return** key to move from one screen to the next. |
| 2 | On Screen 3, the payer information is reviewed for correctness. The patient may have more than one insurance policy. If the correct information is not displayed, select a section (1, 2, or 3 ) and edit the necessary fields. Press **Return** to continue to Screen 5.<br>*For Pharmacy claims, change the form type to a HCFA 1500.* |

```
IB,PATIENT5    000-00-0000   BILL#: K303XX - Outpat/UB92            SCREEN <3>
================================================================================
                               PAYER INFORMATION
[1] Rate Type  : REIMBURSABLE INS.           Form Type: UB-92
    Responsible: INSURER                     Payer Sequence: Primary
    Bill Payer : UNSPECIFIED                 Transmit: No-Ins. co transmit off

 Insurance   COB Subscriber ID     Group       Holder  Effectve  Expires   Only
 ================================================================================
 BLUE CROSS   p  PPAXXXXXXXXX      13000       SPOUSE  01/01/00            IOrM
 MEDICARE(W      XXXXXXXXXA        PART A      SELF    11/01/96           *WNR*
 MEDICARE(W      XXXXXXXXXA        PART B      SELF    07/01/99           *WNR*

[2] Facility ID #s: UNSPECIFIED [NOT REQUIRED]

[3] Mailing Address :
    NO MAILING ADDRESS HAS BEEN SPECIFIED!   (Patient has Medicare)
    Send Bill to PAYER listed above.

<RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT:
```

| Step | Procedure |
|---|---|
| 4 | The highlighted fields are auto-populated. Remember that this is a professional bill that is being transmitting as a HCFA 1500, so each HCPCS code will have to be associated with a diagnosis code. To begin this process, type **4** to edit the **Cod. Method** field and press the **Return** key. |

```
IB,PATIENT5    000-00-0000   BILL#: K303XX - Outpat/HCFA            SCREEN <5>
================================================================================
                          EVENT - OUTPATIENT INFORMATION
<1> Event Date : XXX XX,XXXX
[2] Prin. Diag.: ISSUE REPEAT PRESCRIPT - V68.1
[3] OP Visits  : UNSPECIFIED
[4] Cod. Method: HCPCS
    CPT Code   : Oral prescrip drug non chemo J8499       V68.1    XXX XX,XXXX
[5] Rx. Refills: WARFARIN SODIUM 5MG (COUMADIN) TAB                XXX XX,XXXX
[6] Pros. Items: UNSPECIFIED [NOT REQUIRED]
[7] Occ. Code  : UNSPECIFIED [NOT REQUIRED]
[8] Cond. Code : UNSPECIFIED [NOT REQUIRED]
<9> Value Code : UNSPECIFIED [NOT REQUIRED]

<RET> to CONTINUE, 1-9 to EDIT, '^N' for screen N, or '^' to QUIT:
```

| Step | Procedure |
|---|---|
| 5 | At the **Procedure Coding Method** field type in **CPT**. |
| 6 | At the **Select Procedure Date** field, re-type the date. |
| 7 | At the **Select Procedure** field, type the appropriate code. Once the code auto-populates the data, type **YES** to confirm. |
| 8 | At the **Provider** field, type the name of the physician. Information related to that provider will auto-populate. |
| 9 | Type the appropriate data related to the **Place of Service** and the **Type of Service**. |
| 10 | Press **Return** until Screen 5 appears. |

```
<<CURRENT PROCEDURAL TERMINOLOGY CODES>>

LISTING FROM VISIT DATES WITH ASSOCIATED CPT CODES
IN OUTPT ENCOUNTERS FILE

================================================================================
NO.  CODE    SHORT NAME                CLINIC           DATE
================================================================================

NO CPT CODES ON FILE FOR THE VISIT DATES ON THIS BILL


PROCEDURE CODING METHOD: HCPCS (HCFA COMMON PROCEDURE CODING SYSTEM)
         // CPT  CPT-4
Select PROCEDURE DATE (X/XX/XX-XX/XX/XX): XX-XX-XX
* Patient has no Visits for this date...

   Select PROCEDURE: J
 Searching for a CPT,(pointed-to by PROCEDURES)
  J8499     Oral prescrip drug non chemo
        ...OK? Yes// Yes  Oral prescrip drug non chem  Rx: 0000000D
PROCEDURES: J8499//
Select CPT MODIFIER SEQUENCE:
PROVIDER: TRAINING,BONIFACE C// ASSOCIATED CLINIC:
DIVISION: MONTGOMERY VAMC//        619
PLACE OF SERVICE: 22       OUTPATIENT HOSPITAL
TYPE OF SERVICE: 1       MEDICAL CARE
EMERGENCY PROCEDURE?: NO//   NO
PRINT ORDER:
```

| Step | Procedure |
|---|---|
| 15 | Notice the association has been made between the diagnosis code and the required CPT code. Press **Return** to move to Screen #7. |

```
IB,PATIENT5    000-00-0000   BILL#: K303XX - Outpat/HCFA          SCREEN <5>
================================================================================
                          EVENT - OUTPATIENT INFORMATION
<1> Event Date : XXX XX,XXXX
[2] Prin. Diag.: ISSUE REPEAT PRESCRIPT - V68.1
[3] OP Visits  : XXX XX,XXXX
[4] Cod. Method: HCPCS
    CPT Code   : Oral prescrip drug non chemo   J8499  V68.1   XXX XX,XXXX
[5] Rx. Refills: RANITIDINE HCL 150MG (ZANTAC) TAB             XXX XX,XXXX
[6] Pros. Items: UNSPECIFIED [NOT REQUIRED]
[7] Occ. Code  : UNSPECIFIED [NOT REQUIRED]
[8] Cond. Code : UNSPECIFIED [NOT REQUIRED]
<9> Value Code : UNSPECIFIED [NOT REQUIRED]

<RET> to CONTINUE, 1-9 to EDIT, '^N' for screen N, or '^' to QUIT:
```

| Step | Procedure |
|---|---|
| 16 | There are no changes to this screen. Ensure the charges pulled up and the procedure code are associated with the diagnosis code. Press **Return** to move to Screen #8. |

```
IB,PATIENT5    000-00-0000   BILL#: K303XX - Outpat/HCFA            SCREEN <7>
================================================================================
                          BILLING - GENERAL INFORMATION
[1] Bill Type   : 131              Loc. of Care: HOSPITAL - INPT OR OPT (INCLU
    Covered Days: UNSPECIFIED      Bill Classif: OUTPATIENT
    Non-Cov Days: UNSPECIFIED         Timeframe: ADMIT THRU DISCHARGE
    Charge Type : UNSPECIFIED        Disch Stat:
    Form Type   : HCFA 1500            Division: MONTGOMERY VAMC
[2] Sensitive?  : UNSPECIFIED                 Assignment: YES
[3] Bill From   : XXX XX,XXXX                   Bill To: XXX XX,XXXX
[4] OP Visits   : UNSPECIFIED
[5] Rev. Code   : 253-WARFARIN SODIUM 5  J8499  1      $36.00  PRESCRIPTION    OFFSET:
$0.00   [NO OFFSET RECORDED]
    BILL TOTAL  :      $36.00
[6] Rate Sched  : (re-calculate charges)
[7] Prior Claims: UNSPECIFIED
```

| Step | Procedure |
|---|---|
| 17 | At the **Select Function** field, type **3** for **Rendering**. |
| 18 | At the **Function Performed By** field, type the provider's name. VistA will identify that provider or return a list for selection. Once the proper provider is selected, at **OK?** prompt, type **YES**. The correct provider's information will auto-populate. |

```
Select FUNCTION: RENDERING
   FUNCTION PERFORMED BY: IB,PROVIDER6

     Searching for a VistA identified provider
  IB,PROVIDER6     IBP      PHYSICIAN     111A     PHYSICIAN
        ...OK? Yes//
  PERFORMED BY: IB,PROVIDER6//
    Provider Specialty On File: 11
  CREDENTIALS: MD//
  PRIMARY INS CO ID NUMBER: 00-0000000// 000-00000
Select FUNCTION:
```

This claim is now ready for submission.

## 4.7. Printed Claims

Some claims should not be transmitted electronically and should be printed locally.

These include:

- Claims requiring clinical attachments such as progress notes;
- Claims containing more than the maximum number of diagnosis codes (9 - Institutional and 8 - Professional);
- Claims containing more than the maximum number of diagnosis pointers (4);
- Institutional claims containing more than the maximum number of procedure codes (999);
- Professional claims containing more than the maximum number of procedure codes/line items (50);
- Institutional pharmacy claims; and
- Secondary claims to Medicare WNR (When Medicare WNR is NOT the primary insurance).

## 4.8. View/Resubmit Claims – Live or Test – Synonym: RCB

A new option View/Resubmit Claims – Live or Test has been added to the EDI menu. This option replaces: Resubmit a Bill; Resubmit a Batch of Bills and View/Resubmit Claims as Test. This option will provide the ability to resubmit claims as test claims for testing or production claims for payment.

| Step | Procedure |
|---|---|
| 1 | At the **Select EDI Menu For Electronic Bills Option**, type **RCB** and press the **Return** key. |
| 2 | At the **Enter (C)laim, (B)atch or (L)ist:** prompt, press the **Return** key to accept the default of **List**. |
| 3 | At the **(A)ll payers or (S)elected Payers?** prompt, type **A** for All Payers. |
| | *If you choose Selected payers, after you enter Blue Cross of CA, for example, you will be prompted to included all insurance companies with the same Electronic Billing ID. This will prevent you from having to enter every BC/BS company defined in your Insurance file.* |
| 4 | At the **Run for (U)B92, (H)CFA 1500 or (B)OTH:** prompt, press the **Return** key to accept the default of Both. |
| | *The Date Range for the search for claims has been restricted to a **maximum of 90 days** to minimize the impact of the search on the system.* |
| 5 | At the **Start with Date Last Transmitted:** prompt, type **T-200** for this example. |
| 6 | At the **Date Last Transmitted:** prompt, press the **Return** key to accept the default of 12/1/04. This will return results for 90 days. |
| 7 | At the **Select Additional Limiting Criteria (optional):** prompt, press the **Return** key without selecting anything additional. |

```
Select EDI Menu For Electronic Bills Option: RCB  View/Resubmit Claims-Live or Test

*** NOTE: 2 '^' ARE NEEDED TO ABORT THE OPTION (^^)
          1 '^' BRINGS YOU BACK TO THE PREVIOUS SELECTION PROMPT(^)

SELECT BY: (C)LAIM, (B)ATCH OR SEE A (L)IST TO PICK FROM?: LIST//
PAYER SELECTION:
Run for (A)ll Payers or (S)elected Payers?: SELECTED PAYERS// A  ALL PAYERS

BILL FORM TYPE SELECTION:
Run for (U)B92, (H)CFA 1500 or (B)OTH: BOTH//

LAST BATCH TRANSMIT DATE RANGE SELECTION:
Start with Date Last Transmitted: t-200  (SEP 02, 2004)
Go to Date Last Transmitted:(9/2/04-12/1/04): 1/1/05//   (JAN 01, 2005)

ADDITIONAL SORT SELECTION CRITERIA:

1 - MRA Secondary Only
2 - Primary Claims Only
3 - Secondary Claims Only
4 - Claims Sent to Print at Clearinghouse Only

Select Additional Limiting Criteria (optional):
```

| Step | Procedure |
|---|---|
| 8 | At the **Would you like to include cancelled claims? No//**: prompt, enter **No**. |
| 9 | At the **Would you like to include claims Forced to Print at the Clearinghouse? No//** prompt, enter **No**. |
| | *Sort by Batch if you want to resubmit batches of claims or Current Payer if you want to resubmit a variety of individual claims.* |
| 10 | At the **Sort By** prompt, enter **B** to override the default of Current Payer. |
| 11 | At the **DO YOU WANT A (R)EPORT OR A (S)CREEN LIST FORMAT?:** prompt, press the **Return** key to accept the default of Screen List. |

```
Would you like to include cancelled claims? No//

Sort By: Current Payer// ??

Enter a code from the list.

     Select one of the following:

          1         Batch By Last Transmitted Date (Claims within a Batch)
          2         Current Payer (Insurance Company)

Sort By: Current Payer// Batch By Last Transmitted Date (Claims within a Batch)

Would you like to include claims Forced to Print at the Clearinghouse? No// No

DO YOU WANT A (R)EPORT OR A (S)CREEN LIST FORMAT?: SCREEN LIST//
```

The following screen is displayed:

```
PREVIOUSLY TRANSMITTED CLAIMS Mar 21, 2005@15:52:10          Page:    1 of 1215
** A claim may appear multiple times if transmitted more than once. **
** T = Test Claim ** R = Batch Rejected
>>># of Claims Selected: 0 (marked with *)


    Claim #     Form  Type   Seq  Status           Current Payer
    Batch: 6050011182  Date Last Transmitted: Nov 30, 2004
1   K500XXX     UB92  OUTPT    P  PRNT/TX          UNITED HEALTHCARE
    Batch: 6050011183  Date Last Transmitted: Nov 30, 2004
2   K500XXX     UB92  OUTPT    P  REQUEST MRA      MEDICARE (WNR)
    Batch: 6050011184  Date Last Transmitted: Nov 30, 2004
3   K500XXX     HCFA  OUTPT    P  PRNT/TX          UNITED HEALTHCARE
    Batch: 6050011185  Date Last Transmitted: Nov 30, 2004
4   K500XXX     HCFA  OUTPT    S  PRNT/TX          SOUTHWEST ADMINISTRATORS
    Batch: 6050011186  Date Last Transmitted: Nov 30, 2004
5   K500XXX     UB92  OUTPT    P  PRNT/TX          AETNA US HEALTHCARE
    Batch: 6050011187  Date Last Transmitted: Nov 30, 2004
6   K500XXX     HCFA  OUTPT    P  PRNT/TX          AETNA US HEALTHCARE
+         Enter ?? for more actions                                    >>>
  Claim(s) Select/De select            View Claims Selected
  Batch Select/De select               Print Report
  Resubmit Claims                      Exit
Action: Next Screen//
```

| Step | Procedure |
|---|---|

12 At the **Action** prompt, type **B** to select batches of claims to resubmit as test or '**C**' to select claims.

13 At the **Select EDI Transmission Batch Number:** prompt, enter the number of the desired batch.

*You may repeat the above, entering as many batch numbers as you want.*

```
PREVIOUSLY TRANSMITTED CLAIMS Mar 21, 2005@16:07:38          Page:    1 of 1215
** A claim may appear multiple times if transmitted more than once. **
>>># of Claims Selected: 1 (marked with *)


    Claim #     Form  Type   Seq  Status           Current Payer
    Batch: 6050011182  Date Last Transmitted: Nov 30, 2004
1  *K500YRJ     UB92  OUTPT    P  PRNT/TX          UNITED HEALTHCARE
    Batch: 6050011183  Date Last Transmitted: Nov 30, 2004
2   K50092T     UB92  OUTPT    P  REQUEST MRA      MEDICARE (WNR)
    Batch: 6050011184  Date Last Transmitted: Nov 30, 2004
3   K500YSF     HCFA  OUTPT    P  PRNT/TX          UNITED HEALTHCARE
    Batch: 6050011185  Date Last Transmitted: Nov 30, 2004
4   K500YSZ     HCFA  OUTPT    S  PRNT/TX          SOUTHWEST ADMINISTRATORS
    Batch: 6050011186  Date Last Transmitted: Nov 30, 2004
5   K500YUD     UB92  OUTPT    P  PRNT/TX          AETNA US HEALTHCARE
    Batch: 6050011187  Date Last Transmitted: Nov 30, 2004
6   K500YUE     HCFA  OUTPT    P  PRNT/TX          AETNA US HEALTHCARE
+         Enter ?? for more actions                                      >>>
  Claim(s) Select/De select              View Claims Selected
  Batch Select/De select                 Print Report
  Resubmit Claims as TEST                Exit
Action: Next Screen//  b   Batch Select/De select
Select EDI TRANSMISSION BATCH BATCH NUMBER: 6050011183
```

| Step | Procedure |
|---|---|

14 When you have entered all of the batches you want, at the **ACTION** prompt, type '**R**' for **Resubmit Claims**.

15 At the **Resubmit Claims:** prompt, press the **Return** key to resubmit the claims for payment.

*The system will inform you of the number of claims that will be resubmitted and whether or not they are being submitted for payment or testing.*

16 At the **Are You Sure You Want To Continue?:** prompt, type **YES** to override the default.

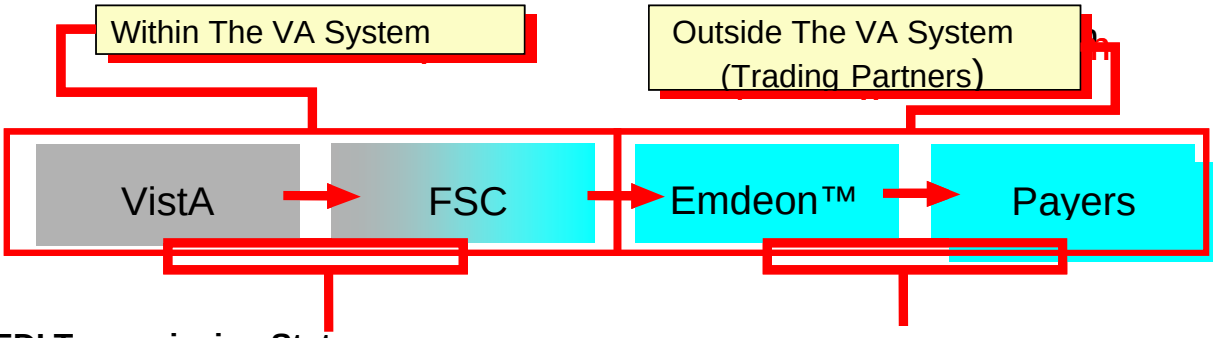
```
You are about to resubmit 2 claims as Production claims.
Are you sure you want to continue?: NO// y  YES
Resubmission in process ...
```

# 5. REPORTS

There are a number of reports available to monitor and manage electronic claims. The EDI menu option can be accessed from the Billing Clerk's Menu.

## 5.1. EDI Reports – Overview

TR reports provide the end-user with information to monitor and manage EDI claims still within the VA, that is, between the VAMC and the FSC in Austin, TX. The MM reports provide the end-user with information and feedback from parties external to the VA such as Emdeon™ and the various electronic payers.




**TR- EDI Transmission Status**

EDI Transmission Status Reports Option Menu
BAR Bills Needing Resubmission Action
DET Batch Status Detail Report
MP EDI Messages Not Yet Filed
PBT Pending Batch Transmission Status Report
PEND EDI Batches Waiting Transmit After 1 day
REX Ready for Extract Status Report
VPE View/Print EDI Bill Extract Data

**MM-EDI Return Message Management**

EDI Return Message Management Option Menu
CSA Claim Status Awaiting Resolution
MCS Multiple CSA Message Management
TCS Test Claim EDI Transmission Report
EDI Message Text to Screen Maint
EDI Message Not Reviewed Report
Electronic Error Report
Electronic Report Disposition
Return Message Filing Exceptions
Status Message Management

## 5.2. Most Frequently Used Menus/Reports

### 5.2.1 Claims Status Awaiting Resolution – Synonym CSA

**What is the purpose of this report?**
Billing and accounts receivable staff use CSA to review the most current status messages and to perform follow-up actions on the bills. Electronic status messages, which include information and rejection messages from the clearinghouse or the payers, are accessed using this option.

**When is this option used?**
This is an option that must be checked **Daily** to determine which claims have rejection or warning messages that were returned from Emdeon™ or from payers. The cause for rejections must be resolved. This option should be used in conjunction with supporting reports (e.g. R022, R0SS, R0SC).

The CSA report contains a Primary, Secondary and Tertiary sort capability and can be sorted by:

| | |
|---|---|
| A | Authorizing Biller |
| B | Bill Number |
| C | Current Balance |
| S | Date of Service |
| D | Division |
| E | Error Code Text |
| N | Number of Days Pending |
| M | Patient Name |
| P | Payer |
| R | Review in Process |
| L | SSN Last 4 |

Once the CSA screen list is displayed, users can select new sort criteria and **re-sort** the list without exiting the option.

Reports can be run showing rejections only (R) or both informational and rejection messages (B). Users most often run the CSA report to show rejections only so they can focus on those claims that require corrective action.

These messages are automatically assigned a status of **Not Reviewed** and require users to review them and make corrections to update this status in IB. Users select a bill from the list to view the details and the entire message text. Messages are marked as **reviewed** or **review in process**. Users may document comments.

*With Patch IB*2.0*320, changes were made to suppress the display of 2Q Claim Status Messages and duplicate claim status messages.*

As messages are reviewed they can be marked as follows:

- Not Reviewed – No action has been taken on a bill that has been returned from the clearinghouse/payer
- Review in Process – While a claim is being reworked, the status can be changed to "Review in Process"
- Review Complete – The error has been resolved and the message from this report will be cleared

Actions such as Cancel Bill, Copy/Cancel Bill, TPJI and Print Bill are available to the user via this option and the user can make needed corrections and re-submit claims from within this option.

Other options available on the CSA include:

- CSA-EDI History Display - The EDI History display option shows all the status messages under the selected bill/message. This information is similar to information that can be viewed under the TPJI menu options.
- CSA-Enter/Edit Comments - The enter/edit comments option gives the user the ability to add a comment onto a bill (status message) in order to inform AR and billing why the issue hasn't been resolved or why the claim was printed to paper.
- CSA-Resubmit by Print - The Resubmit by Print action is used when the user reviews the status message or bill and determines the only way to correct the problem is to submit the claim on hard copy as it cannot pass the electronic edits. The user may "resubmit by print" to the payer instead of retransmitting electronically. If printed from this option, users will be asked if they wish to "review complete" the status message, which will automatically clear it from the report.
- CSA-Retransmit a Bill - Similar to the Resubmit by Print action, the Retransmit Bill is used when the user reviews the status message or bill and determines the reason for the rejection has been corrected elsewhere in the system and the claim just needs to be resent. The user may then retransmit to the payer.
- CSA-Review Status - A bill will continue to show up on the report until it is cancel/cloned, canceled or the status is changed to Review Complete.

Users also have access to the option Multiple CSA Message Management from within the CSA list if they hold the IB Message Management security key.

### 5.2.2 Multiple CSA Message Management – Synonym: MCS

**What is the purpose of this option?**

This option is designed to allow users to take action on CSA messages when a problem arises during the processing of electronic claims that causes a large volume of erroneous status messages to be sent to the site. This option performs tasks similar to the CSA option.

*This option is locked by the **IB Message Management** security key.*

**When is this option used?**
This option is used when there are pages of erroneous messages in CSA that were caused by a processing problem. Use this option to take a similar action (such as retransmission of the associated claims) on multiple claims at the same time.

The initial search for claims and claims status messages is done automatically when the option is selected. The initial search results in the display of all claims that are **Not Cancelled** and for which the review status is **Not Reviewed** or **Review in Process**.

*If someone else is working on a claim in CSA, it will not display in MCS. Only one user can be in MCS at a time. The following message will be displayed: **Sorry, another user is currently using the MCS option. Please try again later.***

Once the initial list has been built, users may further refine their search or work from the default list.

*The purpose of MCS is to select multiple claims and then apply the same action to all the selected claims. For example, users can enter a comment once and then apply the comment to 1-n claims.*

Other actions available on the MCS include:
- Message Search – Allows the user to change the criteria upon which the list of claims will be built
- Change Review Status – Same as CSA
- Cancel Claims – Same as CSA
- Enter Comment – Same as CSA
- Resubmit by Print – Same as CSA
- Retransmit Bill – Same as CSA
- Select/Deselect Claims – Allows users to select the claims to which they want to apply an action

*When using the Resubmit by Print action, the claims selected will not be removed from the list of claims until the claims have actually been printed.*

### 5.2.3 Electronic Report Disposition

**What is the purpose of this option?**
This option allows the site to determine which clearinghouse generated electronic messages/reports are to be sent to the EDI mail group and which should be ignored.

**When is this option used?**

The default setting on this report will contain a disposition of “Mail Report to Mail Group”. It is up to the individual site’s supervisory staff to determine what reports should be ignored.

*Further explanations of these reports are available in documents provided by Emdeon™. They are entitled Claim Submitter Reports – Commercial Batch Systems and Production Reports – Reference Guide. They are available at https://vaww1.va.gov/cbo/ebiz.html*

The following reports must be reviewed **Daily** along with the CSA: WHY? Because they contain payer edits that cannot be translated into claim status messages, this information is not available in CSA.

**R0SC PROF. GOV'T PAYER EDITS**
This report contains the payer edits on professional government claims (Blues and Tricare). The claim status messages contained in this report cannot be translated into status messages.

The following four reports supplement information found on the CSA report:

**R059 UNPROCESSED CLAIM REPORT**
Identifies claims that cannot be processed by the payer and the corrective action that should be taken.

**R060 REQUEST FOR ADDITIONAL INFO**
Lists claims that require additional information for processing. Each message identifies the information required to process the claims and the payer contact.

**R061 ZERO PAYMENT REPORT**
Lists claims for which the payer had determined no payment will be made. Reports should be forwarded to the A/R department.

**R000 NETWORK NEWS**
Provides news on system problems, updates and other pertinent information.

**Other Supplemental Reports**
The following reports contain information that appears on the CSA report:

**R022 PROV DAILY ACCEPT/REJECT**
This report contains the total of claims submitted, accepted, and rejected, by batch, for each provider. Rejected batches and rejected claims are listed with detailed error explanations.

**RO23 PROVIDER DAILY SUMMARY**
Shows the number of accepted claims per batch. Also has a totals section that displays all input, accepted, and rejected daily, month to date and year to date statistics.

**R026 DAILY ACCEPTANCE RPT BY PROV**
Lists the claims Emdeon™ accepted and sent to payers.

**R028 PROVIDER MONTHLY SUMMARY**
Displays the number of accepted claims sent to the payers with month to date and year to date statistics.

**R062 CLAIM SETTLEMENT REPORT**
Explains the disposition of adjudicated claims.

**R0EX INST. GOV'T PAYER EDITS**
This report is the payer's acknowledgement of a file received. The claims listed here were transmitted to the indicated payer for processing.

**R0N9 INST. GOV'T EMDEON™ EDITS**
This report shows Emdeon™'s acknowledgement of a file received.

**R0SA PROF. GOV'T EMDEON™ ACCEPTANCE**
This report shows claims accepted by the Emdeon™ OKC Clearinghouse.

**R0SR PROF. GOV'T EMDEON™ REJECTS**
This report lists the claims rejected by the Emdeon™ OKC Clearinghouse.

**R0SS PROF. GOV'T EMDEON™ EDITS**
Summary of both claims accepted and claims rejected by the Emdeon™ OKC Clearinghouse.

### 5.2.4 Batch Status Detail Report - Synonym: DET

**What is the purpose of this report?**
View electronic transmission status by batch or date transmitted to assure claims are received in a timely fashion by FSC.

**When is this option used?**
It is recommended that initially this report be viewed daily, as it provides transmission status of all claims that were successfully batched and transmitted to FSC Austin. Users should see the status of "Pending Austin Receipt" for the batch followed by "Received in Austin" for each claim in the batch. Once a comfort zone is established and everything is flowing correctly, this report may only need to be run monthly.

Reports can be sorted by:

B BATCH
D LAST DATE TRANSMITTED
S LATEST BATCH RECEIPT STATUS

Other transmission statuses will follow upon successful transmission to Emdeon™ and, ultimately, to the payer. The status of "Accepted by Non-payer," indicates that Emdeon™ or the clearinghouse received the claim. Similarly, "Accepted Payer", "Cancelled", "Corrected/Retransmitted", "Error Condition", and "Closed" are other transmission statuses.

## 5.3. Additional Reports and Options

### 5.3.1 Ready for Extract Status Report - Synonym: REX

**What is the purpose of this report?**
This report provides a list of claims held in a Ready for Extract status. These claims are held in a queue until batching occurs.

**When is this option used?**
Initially this option is used to assure claims are being transmitted at the times set in the MCCR Site Parameters. This option should by reviewed daily until there is a comfort level with the transmission timeframes and then less frequently based on local experience.

Claims that are trapped due to the EDI parameters being turned off can also be viewed. It is rare that EDI is turned off during processing. If this occurs, use EXT Extract Status Management to Cancel or Cancel/Clone/Auth the trapped claims.

Choices to view are:

1 All bills in Ready for Extract status
2 Bills trapped due to EDI parameter being turned off
(If EDI is on, no bills will be trapped in extract)

### 5.3.2 Transmit EDI Bills – Manual - Synonym: SEND

**What is the purpose of this option?**
This option is used to by-pass the normal daily/nightly transmissions queues if the need arises to get the claim to the payer quickly.

**When is this option used?**
There are occasions when there is a need to transmit a claim(s) immediately instead of waiting for the batching frequency as scheduled in the MCCR Site Parameter. This option will allow sending individual claim(s) or all claims in a ready for extract status.

Select one of the following:
A Transmit (A)LL bills in READY FOR EXTRACT status
S Transmit only (S)ELECTED bills

### 5.3.3 EDI Return Message Management Menu – Synonym: MM
This menu contains the options needed to define the types of electronic reports from the clearinghouse that the site needs to see and defines the text that should/should not allow automatic review and filing for informational status messages. It also contains an option to purge old status messages, reports for maintaining the integrity of the return message subsystem and the option for reviewing electronically returned messages.

### 5.3.4 EDI Message Text to Screen Maintenance

**What is the purpose of this option?**
This option controls what status and/or error messages users may wish to review using special text words and/or phrases. This will either require the message to be reviewed or it will auto-file the message and flag it as not needing a review.

This option allows for the display of a list of words or phrases that, if found in the text of an informational status message, will either always require the message to be reviewed or will auto-file the message and flag it as not needing a review.

**When is this option used?**
Depending on what types of status messages users wish to review for follow-up on rejected claims and/or monitoring claims status, users may want to add or edit additional text as needed.

The words and phrases for “Requiring Review” and “Not Requiring Review” will initially populate as shown in the screen print below. This option is used to edit or add more words or phrases, as required, to manage and control the status messages.

### 5.3.5 EDI Messages Not Reviewed Report

**What is the purpose of this report?**

This option allows for the display of all EDI return messages that were filed without needing a review based on the text entries in the message screen text file.

**When is this option used?**
The report can be run for a user-selected date range, based on the date the message was received at the site, and may be sorted by the message text that caused the message to not need a review or by the bill number. Users may want to use this option for analysis or review of all EDI messages that they were not able to view initially.

### 5.3.6 Electronic Error Report

**What is the purpose of this report?**
This report provides a tool for billing supervisors and staff to identify the "who, what, and where" of errors in the electronic billing process. This is a report that will allow the supervisory staff to review "frequently received" errors. This is an informational management tool requiring no actions on the part of the billing staff.

**When is this option used?**
This option can be used at any time by a supervisor or other management staff when they want to determine the reason for various errors (i.e., the same error being made by one or more of the billing staff). The report can be sorted by:

A AUTHORIZING BILLER
B BILLED AMOUNT
E EPISODE OF CARE
P PATIENT NAME
S PATIENT SSN
Y PAYER NAME
C ERROR CODE

### 5.3.7 Return Messages Filing Exceptions

**What is the purpose of this option?**
After users have transmitted claims and they have been received for EDI processing, a message will be sent to the mail groups shown in the set-up section of this manual.

**When is this option used?**
When a message is sent, it is temporarily stored in the "EDI MESSAGES" file. Normally, these messages are in and out of this file in a matter of seconds. If, however, a problem is detected and a message cannot be filed in the appropriate file (s) for its message type, the message will remain in this temporary file.
There are two (2) ***statuses*** for messages in this file.

- **Pending**: The task to force a message to update the IB files has either not yet been created or has been created, but has not yet begun to run.
- **Updating**: The task to force a message to update the IB files has started. It may or may not still be running. If you try to file a message with this status, a

check is made to see if it is currently running. If it is, the message will not be re-tasked.

Any message may be viewed or printed. This does not affect the message in any way, but looking at the message may help to indicate the next course of action needed.

There are two (2) ***actions*** available to get these messages out of the file.

- **File Message**: This action re-executes the tasked job to update the database with the contents of the message.
- **Delete Message**: This is a drastic action that should only be taken when it has been determined there is no other possible way to process a message. When a message is deleted using this action, a bulletin is sent to the IB EDI Mail Group with the text of the message and the name of the user who deleted the message. Users must hold the IB SUPERVISOR security key to perform this action.

### 5.3.8 Status Message Management

**What is the purpose of this option?**
This option allows users to print/purge electronically returned status messages that have been in a final review status for a user-selected number of days.

**When is this option used?**
There will be an accumulation of status messages in a final review status. This option will delete or purge status messages in one of the Final Review statuses prior to a selected date. Auto purging of messages can also be set in the IB Site Parameters.

This report can be sorted by:
A ALL STATUS MESSAGES
S SELECTED STATUS MESSAGES

Selected status message reports can be run showing:
A Auto Filed/No Review Only
B Bill Number
S Message Severity
T Specific Message Text

### 5.3.9 Bills Awaiting Resubmission – Synonym: BAR

**What is the purpose of this report?**
This report lists all batches that have been resubmitted but which did not include all of the bills from the original batch. These are batches that have at least one bill still not resubmitted or canceled.

**When is this option used?**

When a batch is identified to have a claim in error, the batch may be re-submitted with the claim in error removed. This option will track and report specific bills in this category. The report can sort data by:

B BILL NUMBER
L LAST SENT DATE
A BILLED AMOUNT
N BATCH NUMBER (LAST SENT IN)

The report will also indicate the "Bill Transmission Status".

### 5.3.10 EDI Messages Not Yet Filed –Synonym: MP

**What is the purpose of this report?**
This report allows you to select receipt, rejection or both message types and a minimum number of days these messages have been in a PENDING or UPDATING status before they will be included on the report. The report will then list all messages in the file that meet these criteria.

**When is this option used?**
This is a status report that allows for review of messages not yet filed.

### 5.3.11 Pending Batch Transmission Status Report – Synonym: PBT

**What is the purpose of this report?**
This report shows the current transmission status of a batch's mail message. It also includes the mail message number; the first and last date/time it was sent. Only batches in a pending transmission status will be on this report.

**When is this option used?**
This is another option to track the batch(s) of claims after authorizing and transmission to be sure all batches transmitted have been received in Austin. Users can omit both the station number prefix at the front of the batch number and the following zeroes and use only the final digits of the batch number for lookup.

### 5.3.12 EDI Batches Waiting Transmit After 1 day – Synonym: PEND

**What is the purpose of this report?**
This report lists all batches by batch number that have been in a PENDING status and have not yet received confirmation of receipt from Austin for more than one (1) day. The report includes the waiting since date and the mail message number for the batch.

```
            REPORT OF BATCHES STILL WAITING AUSTIN RECEIPT AFTER 1 DAYPAGE: 1
                        BATCH TYPE: EDI 837 BILL SUBMISSION
                            RUN DATE: 7/1/04@12:37:33

      BATCH #        WAITING SINCE              MAIL MESSAGE #
  ------------------------------------------------------------------------

      5500005172    Apr 21, 2004@12:20:51     18462
      5500005173    Apr 30, 2004@14:24:40     18890
      5500005174    May 13, 2004@14:00:04     19774
      5500005175    May 13, 2004@14:00:05     19775
      5500005176    May 13, 2004@20:00:07     19784
      5500005177    May 18, 2004@12:17:41     19861
      5500005178    May 18, 2004@14:00:04     19864
      5500005179    May 18, 2004@15:35:28     19871
      5500005180    Jun 09, 2004@11:32:51     20707
      5500005181    Jun 09, 2004@11:55:06     20709
      5500005182    Jun 09, 2004@13:48:58     20712
      5500005183    Jun 09, 2004@14:00:07     20715
      5500005184    Jun 09, 2004@14:00:09     20716
      5500005185    Jun 09, 2004@14:13:35     20721
Enter RETURN to continue or '^' to exit:
```

*Members of the G.IB EDI mailgroup will receive an email message when there are batches of claims that have not received a confirmation message from Austin after 1 day.*

```
Subj: EDI BATCHES WAITING AUSTIN RECEIPT FOR OVER 1 DAY  [#21387]
06/19/04@19:02  6 lines
From: XXXXXXXXXX,XXXX X  In 'IN' basket.   Page 1  *New*
------------------------------------------------------------------------------
There are 30 EDI batch(es) still pending Austin receipt
for more than 1 day.  Please investigate why they have not yet been confirmed
as being received by Austin.

Since there were more than 10 batches found, please run the
  EDI BATCHES WAITING FOR AUSTIN RECEIPT OVER 1-DAY report to get a list of the
se batches.

Enter message action (in IN basket): Delete//
```

**When is this option used?**

Users may use this option to obtain Batch or Messages numbers when a problem arises or to monitor the status of batches recently transmitted. Batches should not be in a "Pending Austin Receipt" status for more than a day.

***Contact IRM** for assistance in finding out why a confirmation message has not been received from Austin.*

*Before contacting IRM, note the **Message Numbers** for the batches that you need investigated. These numbers can be found in both the **PEND** and **DET** options.*

*If IRM needs assistance, log a **REMEDY ticket** or call the **VA Service Desk at 1-888-596-4357.***

### 5.3.13 View/Print EDI Bill Extract Data – Synonym: VPE

**What is the purpose of this option?**
This option will display the EDI extract data for a bill.

**When is this option used?**
This option is used only if there is a need to determine what data was transmitted for a specific bill. The detailed extract data will contain all the elements in the flat file that is transmitted to FSC Austin. FSC Austin, in turn, translates the data to a HIPAA-compliant format for transmission to Emdeon™.

### 5.3.14 Insurance Company EDI Parameter Report – Synonym: EPR

**What is the purpose of this option?**
This option will display the EDI Parameters of the Active Insurance Companies defined in Vista.

The contents of the following parameters will be included in this report:

- Insurance Company Name
- Street Address and City of Insurance Company
- Electronic Transmit?
- Institutional Electronic Bill ID
- Professional Electronic Bill ID
- Electronic Type
- Type of Coverage

```
All Companies            Insurance Company EDI Parameter Report                    Page: 1
Sorted By Ins Company Name
Mar 21, 2005@14:03:32
Only Blank or 'PRNT' Bill ID's = NO
                                          Electron  Inst  Prof Electronic
Insurance Company Name  Street Address  City    Transmit   ID    ID  Type        Type of Coverage
=============================================================================================
AETNA LIFE INSURANCE    741.. STREET    …,CA    YES-LIVE  XXXXX     Commercial   Health Insurance
```

**When is this option used?**
This option can be used whenever there is a need to confirm that the Insurance Company parameters are correctly defined to support the electronic transmission of claims. This option will be of value when the eClaims Plus patches are loaded and sites gain the ability to transmit secondary claims to the payers (electronic, end-to-end processing). For example, sites can use this option to make sure the payers' Electronic Bill IDs are defined.

### 5.3.15 Test Claim EDI Transmission Report - TCS

**What is the purpose of this option?**
The Claim Status Messages for claim(s) and batch(es) submitted via the RCB option as Test claims will not appear in CSA. No action will be required in response to these

messages. For informational purposes, these messages will be available through the Test Claim EDI Transmission Report. This option can be used to investigate the status of test claims to see, for example, whether the transmission was accepted/rejected by FSC or accepted/rejected by Emdeon™.

*The messages in this option will be automatically purged after 60 days.*

**When is this option used?**
This option can be used whenever a user needs to investigate the current status of a claim or batch of claims. The messages in this report will be like the messages in TPJI.

```
Test Claim EDI Transmission Report                                    Page: 1
Selected Batches                                        Mar 22, 2005@12:14:38
================================================================================

Batch#:  6050011719
Claim#:  K404XXX    IB,Patient7      (Hcfa, Prof, Outpat)
--------------------------------------------------------------------------------
Transmission Information
 03/17/2005@11:11:25  Bch#11719  IB,Clerk2   CIGNA HEALTHCARE  (S)
```

### 5.3.16 Third Party Joint Inquiry – Synonym: TPJI

**What is the purpose of this option?**
This option provides a convenient location for both claim, AR, Insurance and EDI data related to a claim.

**When is this option used?**
This option is used by both Integrated Billing and Accounts Receivable personnel who require information about a claim.

The following actions are available from TPJI

| | |
|---|---|
| BC | Bill Charges |
| DX | Bill Diagnosis |
| PR | Bill Procedures |
| CB | Change Bill |
| ED | EDI Status |
| AR | Account Profile |
| CM | Comment History |
| IR | Insurance Reviews |
| HS | Health Summary |
| AL | Active List |
| VI | Insurance Company |
| VP | Policy |
| AB | Annual Benefits |
| EL | Patient Eligibility |

### 5.3.17 Patient Billing Inquiry – Synonym: INQU

**What is the purpose of this option?**
This option provides some basic information about a particular claim. It is a simple inquiry option.

**When is this option used?**
This option can be used to view the following type of information related to a bill:

- Bill Status
- Rate Type
- Form Type
- Visit Date(s)
- Charges
- AR Status
- Statement Dates
- Dates related to actions such as Entered, Cancelled or Printed
- Bill Number copied from or to
- Patient, Mailing and Insurance Company address

The data available varies based upon when the inquiry is made and what actions have been carried out regarding the claim.

# 6. APPENDIX A – BATCH PROCESSING SETUP

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## BATCH PROCESSING SETUP

The following example shows you how to define batch processing for a payer:

| Step | Procedure |
|---|---|
| 1 | Under the IB Site Parameters, go to **field [15] EDI/MRA Activated**. |
| 2 | Edit fields as necessary (fields are highlighted in yellow for this example). |

*Details on each field follow the screen example.*

*When the MRA software was loaded (Patch IB*2.0*155), the **EDI/MRA Activated** field was removed from this screen. Only **IRM** is able to access this field via **Fileman**. The reason for this is to prevent MRA from being activated before the FSC is ready to accept MRA transmissions from a particular site.*

```
IB Site Parameters            Aug 13, 2003@10:22:46          Page:    5 of 6
Only authorized persons may edit this data.
+---------------------------------------------------------------------------

[15] EDI/MRA Activated               : EDI

     EDI Contact Phone               :

     EDI 837 Live Transmit Queue     : MCH

     EDI 837 Test Transmit Queue     : MCT

     Auto-Txmt Bill Frequency        : Every Day

     Hours To Auto-Transmit          : 1300;1600

     Max # Bills Per Batch           : 50

     Only Allow 1 Ins Co/Claim Batch?: NO

     Last Auto-Txmt Run Date         : 08/13/03

     Days To Wait To Purge Msgs      : 120
```

**EDI/MRA Activated**: Controls whether EDI is available for the site. Choose from:

0 - NOT EDI OR MRA;
1 - EDI ONLY;
2 – MRA ONLY; or
3 – BOTH EDI AND MRA

You will have to reset this to **3** when you want to activate **MRA.**

Following the installation of MRA, there will be additional fields that you must define.

```
IB Site Parameters            May 27, 2004@14:14:24          Page:    5 of    6
Only authorized persons may edit this data.
+
```

```
      HMO NUMBER                    :
      STATE INDUSTRIAL ACCIDENT PROV:
      LOCATION NUMBER               :

[15] EDI/MRA Activated               : BOTH EDI AND MRA
     EDI Contact Phone               : 217-554-3135
     EDI 837 Live Transmit Queue     : MCH
     EDI 837 Test Transmit Queue     : MCT
     Auto-Txmt Bill Frequency        : Every Day
     Hours To Auto-Transmit          : 1000;1400;2000
     Max # Bills Per Batch           : 10
     Only Allow 1 Ins Co/Claim Batch?: NO
     Last Auto-Txmt Run Date         : 05/26/04
     Days To Wait To Purge Msgs      : 45
     Allow MRA Processing?           : YES
     Enable Automatic MRA Processing?: YES

+         Enter ?? for more actions
EP  Edit Set                                    EX  Exit Action
```

**EDI Contact Phone:** The phone number of the person at the site contact to whom EDI inquiries will be directed. It will appear on the UB92 in box 1 and on the HCFA 1500 in box 32.

**EDI 837 Live Transmit Queue:** The name of the Austin data queue that will receive claims to be processed via a live connection to the clearinghouse. These data are populated at the time of installation and would not normally be edited by the site.

**EDI 837 Test Transmit Queue:** The name of the Austin data queue that will receive test claims. These data are populated at the time of installation and would not normally be edited by the site.

**Auto Transmit Bill Frequency**: The desired number of days between each execution of the automated bill transmitter. For example, if the automated bill transmitter should run only once a week, this number would be 7. If the automated bill transmitter should run every night, then the number should be 1. If this is left blank or zero then the automated bill transmitter background job will never run.

**Hours To Transmit Bills:** Contains the times of the day when EDI transmission of bills should occur. A maximum of 4 daily times daily may be entered and the times must be separated by a semi-colon. Times must be entered in 4-digit military format, without punctuation (HHMM;HHMM;HHMM;HHMM). If no times are entered, EDI transmission will take place as a normal part of the nightly job.

**Max # Of Bills In A Batch:** The maximum number of bills allowed in a single batch. With a new payer, it is suggested that you begin with fairly small batches (10-20 claims).

**Only Allow 1 Ins Co/Claim Batch:** Indicates whether or not the site wishes to limit batches to claims for a single insurance company.

**Last Auto-Txmt Run Date:** The last date the auto transmit of bills was run at the site. These data are display only and cannot be edited.

**Days To Wait To Purge Msgs:** This is the number of days after an electronic status message has been marked reviewed, that the purge message option can delete it from the system.

# 7. APPENDIX B – GLOSSARY

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# GLOSSARY OF TERMS

| | |
|---|---|
| 835 | The HIPAA adopted standard for electronic remittance advice to report the processing of all claim types (including retail pharmacy). The 835 is sent from health plans to health care providers and contains detailed information about the processing of the claim. This includes payment information and reduction or rejection reasons. The 835 transactions generally contain information about multiple claims. All health plans are required to use the same explanation of benefit codes (adjustment reason codes) and adhere to very specific reporting requirements. The term "835" is used interchangeably with electronic remittance advice. |
| 837 | The HIPAA adopted standard for electronic submission of hospital, professional and dental claims or encounters. The 837 is sent from health care providers to health plans (payers). The 837 transactions are generally multiple claims (batches). The 837 standard includes the information for coordination of benefits and is also used for secondary payer claims submission. The term "837" is used interchangeably with electronic claim. |
| Billing Provider Secondary ID Number | This is either the facility tax ID # (default) or an ID assigned to the facility by the insurance company. |
| Care Unit | Specific data related to patient care (pre-defined by an insurance company) that provides the insurance company with a finer breakdown of the care being billed. The data that comprises the breakdown are insurance company specific and are not required by all payers. (For example, Orthopedics, Dermatology, Urology, etc.) |
| Claim Status Message | Electronic messages returned to the VAMC providing status an information on a claim from the Financial Service Center (FSC), Emdeon™ Envoy Clearinghouse or a payer. |
| Clearinghouse | A company that provides batch and real-time transaction processing services. Transactions include insurance eligibility verification, claims submission process and electronic remittance information and payment posting for electronic claims. |
| CSA | Claims Status Awaiting Resolution<br><br>Used to reference the option used by billing staff to review the most current status messages received for a bill(s) and do follow-up on the bills. Users will be able to select a bill from the list to view the details and the entire message text as well as to |

| | |
|---|---|
| | mark the message as reviewed or under review and document user comments. |
| eClaim | A claim that is submitted electronically from the VA. |
| EDI | Electronic Data Interchange. Electronic Data Interchange (EDI) is the process of transacting business electronically. It includes submitting claims electronically (paperless claims processing), as well as electronic funds transfer and electronic inquiry for claim status and patient eligibility. |
| Electronic Payer | A payer that has an electronic connection with Emdeon™ Envoy, the clearinghouse. |
| Emdeon™ | The clearinghouse that transmits all VA claims to payers, or prints and mails claims to payers that do not have an electronic connection. |
| Envoy | The previous name of the clearinghouse, currently named Emdeon™ Envoy. |
| ePayer | Payer that accepts electronic claim from the clearinghouse pays electronically. See Payer. |
| EVS (Formerly NVS) | Enterprise Vista Support |
| Express Bill | Emdeon™ Envoy's print house that prints and mails claims to payers who do not have the capability to accept electronic claims or in specific circumstances when a paper claim is required. |
| Facility Fed Tax ID # | This is the number that will be the default for all providers for the ID type at the facility if the payer does not have specific requirements. |
| Fiscal Intermediary | A fiscal intermediary performs services on behalf of health care payers. These services include claim adjudication, reimbursement and collections. Trailblazer is an example of a fiscal intermediary that acts on behalf of Medicare. Trailblazer receives claims from the VA in the form of an 837 file and then adjudicates the claims to create a MRA/EOB 835 file. |
| Form Types | The UB-92 or HCFA 1500 billing form on which services will be billed. |
| FSC | The VA Financial Services Center in Austin. The Financial Service Center translates claims into an industry-standard format (HIPAA 837) and forwards claims to the clearinghouse. The FSC is the single point for the exchange of data between VistA and Emdeon™ Envoy. |
| Healthcare Company | See Payer. |
| HIPAA | Health Insurance Portability and Accountability Act. Health |

| | |
|---|---|
| | Insurance Portability and Accountability Act. In 1996 Congress passed into law the Health Insurance Portability and Accountability Act (HIPAA). This Act is comprised of two major legislative actions: Health Insurance Reform and Administrative Simplification. The Administrative Simplification provisions of HIPAA direct the federal government to adopt national electronic standards for automated transfer of certain health care data between health care payers, plans, and providers. This will enable the entire health care industry to communicate electronic data using a single set of standards thus eliminating all non-standard formats currently in use. Once these standards are in place, a health care provider will be able to submit a standard transaction for eligibility, authorization, referrals, claims, or attachments containing the same standard data content to any health plan. This will "simplify" many clinical, billing, and other financial applications and reduce costs. |
| Insurance Company | See Payer. |
| Merge Facility | This activity occurs when two or more VAMCs consolidate billing functions and all of the facilities adopt the parent site's tax ID. |
| Move Facility | This activity occurs when two or more VAMCs consolidate billing functions but each facility retains it's own tax ID. |
| Non-VA Facility | Any facility that provides services to a VA patient and subsequently bills the VA for those services. |
| Non-VA Provider | Any individual provider who provides services to a VA patient and subsequently bills the VA for these services |
| Only 1 Ins Co Per Claim Batch | This field indicates whether or not the site want a batch of electronic claims to contain claims to a single insurance company only. |
| Parent | The top facility in a hierarchical domain. |
| Payer | The insured's insurance company. Other terms that are used to denote Payer include, ePayer, insurance company, healthcare company, etc. |
| Payer Code | A code used for enrollment that uniquely identifies the payer. If CALL is listed as the payer code, the payer has requested to be contacted for the actual code. |
| Payer List | List of payers that consist of the payer category, claim type, payer code, and payer name. |
| Provider | Provider of health care services. |
| Provider ID | A provider ID can represent a facility or an individual |

| | |
|---|---|
| | physician/provider. |
| UPIN | Unique Provider Identification Number. |
| URL | Uniform Resource Locator. |
| VAMC | Veterans Affairs Medical Center. |
| VISN | Veterans Integrated Service Network. |

# 8. APPENDIX C –HIPAA PROVIDER ID –REFERENCE GUIDE

APPENDIX C –HIPAA Provider ID –Reference Guide

This table displays the HIPAA qualifiers and associated ID types. This table can be used to help identify what type of Provider ID type is being used in the electronic format.

| Institutional | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Qualifier | | Billing Provider | Attending | | Operating | | Other | | Service | |
| | Definition | 2010AA | 2310A | 2330D | 2310B | 2330E | 2310C | 2330F | 2310E | 2330H |
| | | | | | | | | | | |
| | | | C | O | C | O | C | O | C | O |
| | | PRV1 | OPR2 | OP1 | OPR3 | OP2 | OPR4 | OP9 | SUB2 | OP3 |
| OB | State License Number | - | OB | | OB | | OB | | OB | |
| 1A | Blue Cross Provider Number | 1A | 1A | 1A | 1A | 1A | 1A | 1A | 1A | - |
| 1B | Blue Shield Provider Number | - | 1B | 1B | 1B | 1B | 1B | 1B | 1B | 1B |
| 1C | Medicare Provider Number | 1C | 1C | 1C | 1C | 1C | 1C | 1C | 1C | 1C |
| 1D | Medicare Provider Number | 1D | 1D | 1D | 1D | 1D | 1D | 1D | 1D | 1D |
| 1G | Provider UPIN Number | 1G | 1G | 1G | 1G | 1G | 1G | 1G | 1G | - |
| 1H | TRICARE ID Number | 1H | 1H | 1H | 1H | 1H | 1H | 1H | 1H | - |
| 1J | Facility ID Number | 1J | - | - | - | - | - | - | 1J | - |
| B3 | PPO Number | B3 | - | - | - | - | - | - | - | - |
| BQ | HMO Code Number | BQ | - | - | - | - | - | - | - | - |
| EI | Employer's ID Number | EI | EI | EI | EI | EI | EI | EI | EI | EI |
| FH | Clinic Number | FH | - | - | - | - | - | - | FH | - |
| G2 | Provider Commercial Number | G2 | G2 | G2 | G2 | G2 | G2 | G2 | G2 | G2 |
| G5 | Provider Site Number | G5 | - | - | - | - | - | - | G5 | - |
| LU | Location Number | LU | LU | LU | LU | LU | LU | LU | LU | LU |
| N5 | Provider Plan Network ID Number | - | N5 | N5 | N5 | N5 | N5 | N5 | N5 | N5 |
| TJ | Federal Taxpayer's ID Number | - | | - | - | - | - | - | - | - |
| X4 | Clinical Lab Improvement Amendment (CLIA #) | - | - | - | - | - | - | - | - | - |
| U3 | Unique Supplier ID Number (USIN) | - | - | - | - | - | - | - | - | - |
| SY | Social Security Number | SY | SY | - | SY | - | SY | - | - | - |
| X5 | State Industrial Accident Provider Number | X5 | X5 | - | X5 | - | X5 | - | X5 | - |
| | | | | | | | | | | |
| C = Current Payer O = Other Payer | | | | | | | | | | |

| Professional | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Qualifier | | Billing Provider | Referring | | Rendering | | Purchased | | Service Facility | | Supervising | |
| | HIPAA Loop | 2010AA | 2310A | 2330 D | 2310B | 2330 E | 2310 C | 2330 F | 2310 D | 2330 G | 2310 E | 2330 H |
| | | | | | | | | | | | | |
| | | | C | O | C | O | C | O | C | O | C | O |
| | VPE Record | PRV1 | OPR5 | OP4 | OPR2 | OP1 | SUB1 | OP6 | SUB2 | OP7 | OPR8 | OP8 |
| OB | State License Number | - | OB | - | OB | - | OB | - | OB | - | OB | - |
| 1A | Blue Cross Provider Number | - | - | - | - | - | 1A | - | 1A | - | - | - |
| 1B | Blue Shield Provider Number | 1B | 1B | 1B | 1B | 1B | 1B | 1B | 1B | 1B | 1B | 1B |
| 1C | Medicare Provider Number | 1C | 1C | 1C | 1C | 1C | 1C | 1C | 1C | 1C | 1C | 1C |
| 1D | Medicare Provider Number | 1D | 1D | - | 1D | - | 1D | 1D | 1D | 1D | 1D | 1D |
| 1G | Provider UPIN Number | 1G | 1G | - | 1G | - | 1G | - | 1G | - | 1G | - |
| 1H | TRICARE ID Number | 1H | 1H | - | 1H | - | 1H | - | 1H | - | 1H | - |
| 1J | Facility ID Number | 1J | - | - | - | - | - | - | - | - | - | - |
| B3 | PPO Number | B3 | - | - | - | - | - | - | - | - | - | - |
| BQ | HMO Code Number | BQ | - | - | - | - | - | - | - | - | - | - |
| EI | Employer's ID Number | EI | EI | EI | EI | EI | EI | EI | | | EI | EI |
| FH | Clinic Number | FH | - | - | - | - | - | - | - | - | - | - |
| G2 | Provider Commercial Number | G2 | G2 | G2 | G2 | G2 | G2 | G2 | G2 | G2 | G2 | G2 |
| G5 | Provider Site Number | G5 | - | - | - | - | - | - | - | - | - | - |
| LU | Location Number | LU | LU | LU | LU | LU | LU | LU | LU | LU | LU | - |
| N5 | Provider Plan Network ID Number | - | N5 | N5 | N5 | N5 | N5 | N5 | - | N5 | N5 | N5 |
| TJ | Federal Taxpayer's ID Number | - | - | - | - | - | | - | TJ | - | - | - |
| X4 | Clinical Lab Improvement Amendment (CLIA #) | - | - | - | - | - | | - | X4 | - | - | - |
| U3 | Unique Supplier ID Number (USIN) | U3 | - | - | - | - | U3 | - | - | - | - | - |
| SY | Social Security Number | SY | SY | | SY | | SY | - | - | - | SY | - |
| X5 | State Industrial Accident Provider Number | X5 | X5 | - | X5 | - | X5 | - | X5 | - | X5 | - |
| | | | | | | | | | | | | |
| C = Current Payer **O** = Other Payer | | | | | | | | | | | | |